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THE MANAGEMENT OF URTICARIA DUE TO PENICILLIN

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The most frequently encountered reaction to sodium penicillin administered parenterally is urticaria. Other reactions affecting the skin have been described, including "id" type reactions on the hands and feet, maculopapular eruptions of various types and erythema multiforme-like lesions.[1] It is our purpose in this paper to summarize our experience concerning the incidence of urticarial reactions during and after penicillin therapy, to cite cases demonstrating the unpredictability of this reaction and to report instances in which reacting patients could, and could not, tolerate continuance of penicillin therapy by the simultaneous administration of compounds having an antihistaminic effect.

Urticaria resulting from penicillin therapy was first reported by Keefer and his associates.[2] Dawson and Hobby[3] observed 3 instances of urticaria in the first 100 patients whom they treated with penicillin. They pointed out that the allergic response to penicillin might be due to impurities in the complex mixture, but this theory has not yet been confirmed or disproved.

Our experience indicates that (1) penicillin reactions are more frequently encountered in patients who have had repeated courses of this drug; (2) some patients who have had an urticarial reaction to penicillin may tolerate further penicillin therapy, while others may not; (3) skin tests with penicillin are unreliable as a means of predicting the occurrence of reactions to penicillin on further administration of the compound; (4) antihistamine compounds, particularly Benadryl,[4] are useful in controlling penicillin urticaria, and (5) urticarial reactions may at times be persistent and severe.

Allergic reactions of various types have been noted after the administration of a wide variety of drugs, and certain principles have been established on the basis of an enormous experience in this branch of dermatology and allergy. However, these principles are often disregarded in connection with new drugs, and this disregard may expose patients to unnecessary risks or may deny them treatment which might well be given with reasonable safety. An admirable summary of reactions to drugs has recently been published by Sulzberger and Baer,[5] and a review of some of the principles outlined by them will be helpful in the management of patients with reactions to penicillin. In particular, the following should be kept in mind: 1. Almost any chemical or biologic compound has some capacity to induce sensitization of various tissues of the body. 2. A reaction noted during or after exposure to a compound may not necessarily occur on reexposure. 3. Cutaneous reactions to a drug may vary considerably in appearance, though certain drugs have a pattern reaction which is the one most likely to be noted after their administration. 4. There is a variable period of incubation between the initial exposure to the drug and the demonstration of sensitivity to it; this period is almost never less than five days but may be as long as months or years. 5. Skin tests are often unreliable indicators of the patient's ability to tolerate further administration of the drug concerned. 6. There may be a considerable delay in the appearance of an eruption due to a drug after a patient's exposure to it, and, also, the eruption may persist for some time after withdrawal of the offending compound.

The antihistamine drugs, Benadryl and, more recently, Pyribenzamine,[6] constitute valuable additions to the methods of treatment of allergic reactions in general, and of urticarial reactions to penicillin in particular. Lowe,[7] Curtis and Owens,[8] Shaffer[9] and O'Leary and Farber[10] have all found Benadryl useful in the treatment of urticaria. Further experience will be required to demonstrate the full usefulness and limitations of these compounds. We are reporting herewith only our experience with them in urticaria due to penicillin; the results with a considerable series of patients afflicted with other allergic reactions involving the skin will be summarized elsewhere.

From the Institute for the Study of Venereal Disease of the University of Pennsylvania, John H. Stokes, M.D., director; and the Department of Dermatology and Syphilology, Donald M. Pillsbury, M.D., director.

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In the first 824 cases of syphilis treated with penicillin and followed at the Institute for the Study of Venereal Disease at the University of Pennsylvania, there were 15 cases of urticaria, an incidence of 1.8 per cent. Each of the 824 patients in this group received at least 1.2 million units of penicillin in 7.5 days or longer and returned to the clinic at regular intervals after the completion of treatment. It is our opinion that this incidence is increasing; 2 cases of urticaria were noted in the first 200 patients treated (November 1943 to August 1944), while treatment of the last 200 patients (October 1945 to May 1946) resulted in 12 cases of urticaria.

The 15 patients who had urticarial reactions all gave negative personal histories in regard to other manifestations of allergy. In 1 of these patients an urticarial eruption developed after each of his two 7.5 day courses of penicillin. In another patient there developed a morbilliform eruption on the fifth day of her first course of treatment. Seven patients acquired urticaria after the second course of penicillin, following an uneventful first course; 5 had hives during or after the third course of treatment, who had no reaction during the preceding two courses, and 1 patient tolerated three courses without incident, only to have urticaria develop shortly after the fourth course was completed.

The cases of certain patients whose varying clinical courses illustrate basic principles underlying the interpretation and management of reactions to penicillin are cited in the following reports.

REPORT OF CASES

Readministration of penicillin after a severe urticarial reaction to it may not be followed by recurrence of the urticaria on reinjection of a full therapeutic dose of penicillin.

CASE 1.—W. D., a Negro man aged 53, was under treatment for meningovascular syphilis, diabetes mellitus and hypertensive cardiovascular disease. He had no personal or familial history of allergic diseases. In the treatment of his syphilitic infection he was given 1.2 million units of sodium penicillin in isotonic sodium chloride solution over a period of eight days in November 1943; a second course of 2.4 million units in eight days in July 1944, and 1.2 million units in 7.5 days in April 1945. Considerable clinical improvement was noted, but because of a persistently positive spinal fluid, grade II, he was readmitted to the hospital Feb. 6, 1946 and received 4.8 million units of sodium penicillin in 7.5 days. Twenty-four hours after discharge on Feb. 13, 1946, there developed large urticarial wheals which were distributed over the entire body. He was readmitted to the hospital on Feb. 15, 1946. Biopsy of one of the cutaneous lesions showed a typical histologic picture of urticaria. The patient was given 100 mg. Benadryl by mouth and was entirely relieved of his pruritus in forty-eight hours. The administration of Benadryl was continued in a dose of 100 mg. orally three times a day; there were only a few wheals remaining in eight hours, and in forty-eight hours there was no evidence of urticaria. On Feb. 17, 1946 the patient was tested by the intradermal injection of 0.1 cc. of isotonic sodium chloride solution containing 1,000 units of penicillin. A zone of erythema 1.2 cm. in diameter was noted at the site of the injection containing the lot of penicillin originally administered to the patient; injection of another lot of penicillin in the same concentration produced an erythematous zone 0.5 cm. in diameter. On the same day the patient was given 1,000 units of penicillin intramuscularly, without reaction. On the following day 40,000 units were administered, without return of pruritus or urticaria.

CASE 2.—D. R., a white man aged 52, was under treatment for tabes dorsalis and received his first course of penicillin in March 1945. He was given 2.4 million units of sodium penicillin in eight days without reaction. Because of persistent tabetic pains he was readmitted in January 1946 and started on 40,000 units of sodium penicillin dissolved in isotonic sodium chloride solution every three hours. On the twelfth day, after the patient had received 3.4 million units, typical urticarial lesions developed, and there was a concomitant, cramping abdominal pain. Penicillin therapy was immediately discontinued, and Pyribenzamine, 50 mg. three times a day, was administered orally. The latter was discontinued after the second dose, because of the vomiting associated with the urticarial reaction. Large gyrate urticarial lesions were present over the entire body three days after the onset, and the vomiting continued. The patient was then given 10 mg. of Benadryl intravenously, following which he became extremely drowsy, and the urticarial lesions were less pronounced. The following morning Benadryl was administered by mouth in a dosage of 100 mg. three times a day. There was no evidence of urticaria two days later, and Benadryl administration was discontinued without recurrence of the lesions. On the sixth day after the onset of urticaria a placebo injection was given without reaction, and on the eighth day 1,000 units of sodium penicillin of the original lot was given without reaction. On the tenth day the patient received 5,000 units, then 40,000 units; the following day he returned to a dosage of 40,000 units every three hours until 1,400,000 units had been received. There was no recurrence of urticaria, pruritus or abdominal pain, in spite of the fact that he was receiving no antiallergic treatment and was being given the original dosage of the same lot of penicillin that apparently caused his allergic reaction.

It is sometimes possible to continue penicillin therapy in a reacting patient by the simultaneous administration of penicillin and an antihistamine compound.

CASE 3.—H. S., a white man aged 50, was first admitted to the hospital May 13, 1944 for treatment of tabes dorsalis. Two and four-tenths million units of sodium penicillin were administered in a period of nine days, without immediate or delayed reaction. The patient was retreated in March 1945 with 2.4 million units of penicillin given over ten days, again without reaction. Because of recurrence of lightning pains, the patient was readmitted to the hospital on March 5, 1946 for additional treatment. From this date until March 12, the patient received 40,000 units of penicillin every three hours. At 9 p. m. on that date there suddenly developed generalized giant urticarial lesions. Penicillin therapy was discontinued, and in eighteen hours the patient's pruritus had diminished but some urticarial lesions were still present. At 3 p. m. on March 13 a test dose of 40,000 units of sodium penicillin was administered intramuscularly. Severe pruritus recurred promptly, and the urticaria become more pronounced. On March 14 the patient was given Benadryl, 100 mg. three times a day by mouth, and penicillin was readministered in a dosage of 40,000 units every three hours. The urticaria disappeared, and the patient tolerated continued penicillin therapy well. On March 18, 1946, the amount of Benadryl was reduced to 150 mg. a day and the dosage of penicillin was maintained at 40,000 units every three hours. The urticaria promptly recurred, and the patient's temperature rose to 102 F. On March 19 the dosage of Benadryl was increased to 300 mg. daily, and again the urticarial lesions disappeared. On March 21 it was again reduced to 150 mg. daily, but there was no recurrence of the urticaria. On March 22 all treatment was discontinued, and the patient did not acquire hives during several weeks of observation thereafter.

Intradermal tests with solutions containing 1,000 units of penicillin in 0.1 cc. were performed. The skin showed no reaction in twenty minutes, twenty-four hours and forty-eight hours to the original lot of penicillin used or to several other lots of penicillin.

Urticarial reactions to penicillin are sometimes not controlled by the administration of Benadryl, may be accompanied by severe gastrointestinal symptoms and may be reprecipitated by the administration of small amounts of penicillin.

CASE 4.—F. M., a white woman aged 50, was under treatment for tabes dorsalis. She gave no personal or familial history of allergic diseases. The initial treatment with penicillin was administered in July 1944, and 3 million units were given in ten days without reaction. Subsequent to this treatment the

patient showed considerable improvement but because of a persistently positive spinal fluid was admitted to the hospital for further penicillin therapy on Nov. 30, 1945 and scheduled to receive a total dose of 7 million units. On Dec. 9, 1945, after 5.2 million units had been administered, a generalized severe urticaria was noted, and treatment with penicillin was discontinued. Twenty-four hours later the urticaria had not improved, and treatment with Benadryl, 300 mg. daily by mouth, was started. There was no lessening of the urticaria twenty-four hours later. Shortly thereafter, abdominal pain, nausea and vomiting developed which were aggravated by the taking of any food, liquid or drug by mouth. Benadryl for intravenous administration was not available, and the patient was treated with epinephrine hypodermically, calcium gluconate intravenously and phenobarbital by mouth, with no effect on the urticaria or vomiting. The urticaria gradually disappeared within a week, and the patient felt entirely well. Nine days after the onset of her reaction, 1,000 units of penicillin from the same lot as that previously used was administered. Two and one-half hours later urticarial lesions reappeared, but there was no nausea or vomiting. On the following morning, when the hives had disappeared, 3,000 units of penicillin were given. Six hours later, the patient observed the development of edema of the lips, but this reaction was not as severe as that following the previous injection of 1,000 units. The lesions cleared up promptly. Further penicillin therapy was not attempted. Skin tests, using 0.1 cc. isotonic sodium chloride solution containing 1,000 units, were performed. Penicillin of the same lot as that used previously on the patient produced erythema 0.5 cm. in diameter in thirty minutes; that from another lot produced erythema 4.0 cm. in diameter, and no reaction resulted from tests with two other lots of penicillin. Intradermal injection of human serum containing 0.1 unit of penicillin per cubic centimeter from a patient receiving penicillin produced no reaction. All twenty-four hour readings were negative.

An urticarial reaction to penicillin therapy may be severe, may be accompanied by asthma, may respond only moderately to Benadryl or Pyribenzamine therapy and may be followed by ecchymoses and uterine bleeding of undetermined cause.

CASE 5.—M. D., a white woman physician aged 31, was first seen at the request of Dr. I. S. Ravdin on April 7, 1946 by Dr. Malcolm Spencer and one of us (D. M. P.) because of severe urticaria, laryngeal edema and asthma developing during prophylactic penicillin therapy following an operation on the left knee. The course of the patient's illness was severe and alarming and the cause of a subsequent hemorrhagic reaction was obscure; the history and clinical course are therefore recorded herewith in some detail.

The patient had been in generally good health, except that at the age of 16 she had undergone a dilatation and curettage because of dysmenorrhea associated with excessive uterine bleeding. This procedure was repeated in August 1945 because of similar symptoms. Sections of the endometrium taken on both occasions were reported to be normal on histologic examination. Further pertinent details may be outlined in chronologic order, as follows:

September 1945. Angioneurotic edema of the perioral region developed following the taking of a total of 360,000 units of penicillin by mouth during a period of three days, because of an infection of the upper part of the respiratory tract associated with diarrhea. The angioneurotic edema disappeared promptly on cessation of penicillin therapy.

March 8, 1946. The patient sustained a fracture of the medial semilunar cartilage in an automobile accident.

March 29, 1946. A medial meniscectomy of the left knee was performed. Prophylactic penicillin therapy in the amount of 30,000 units every three hours, intramuscularly, was started.

April 7, 1946. After eight days of satisfactory progress, there developed in the patient severe generalized urticaria, with several paroxysms of asthma. Penicillin therapy was suspended, and the patient was started on Benadryl in a dosage of 100 mg. three times a day.

April 8 and 9, 1946. The patient continued to have urticaria, laryngeal edema and asthma, for which a number of injections of epinephrine were required for relief.

April 10, 1946. Benadryl was adjudged to have been ineffective, and treatment with Pyribenzamine, 100 mg. by mouth three times a day was started. There was possibly some improvement in the urticaria, but the patient continued to have asthmatic attacks between 10 p. m. and 3 a. m.

April 11, 1946. The dosage of Pyribenzamine was increased to 50 mg. every four hours, around the clock. The asthmatic attacks disappeared, but occasional hives persisted.

April 12, 1946. The dosage of Pyribenzamine was increased to 75 mg. every four hours. The urticaria remained troublesome, and on April 13 the dose was increased to 100 mg. every four hours. Complete freedom from asthma and urticaria occurred. There were no apparent untoward side effects from Pyribenzamine.

April 14, 1946. Because of shortage in the supply of Pyribenzamine, the dosage was reduced to 50 mg. every four hours. Urticaria shortly recurred. On April 15 the dosage was increased to 75 mg. every four hours, and this apparently relieved the urticaria. The patient was discharged from the hospital.

April 17, 1946. The dosage of Pyribenzamine was reduced to 50 mg. every four hours, and urticaria recurred.

April 18, 1946. Benadryl, 10 mg. in 20 cc. isotonic sodium chloride solution, was administered intravenously. Urticarial lesions disappeared almost immediately, and the patient slept for ninety minutes.

April 19, 1946. The patient resumed Pyribenzamine therapy, 100 mg. every four hours. The dose was then gradually reduced, and on April 23 Pyribenzamine was discontinued entirely, although occasional small hives were still being noted.

Benadryl and Pyribenzamine in the Treatment of Urticaria Due to Penicillin

	Total Cases Treated	Relief with Dose of 50-100 Mg. Three Times a Day	No Relief
With benadryl	16	14	2*
With pyribenzamine	7	2	5

* These patients received one dose of 10 mg. of benadryl intravenously, with temporary relief.

April 24, 1946. While visiting her home in another city, the patient noted vaginal bleeding which required three to four pads in twenty-four hours. The last previous menstrual period had started on April 10. The vaginal bleeding continued and on April 26 the patient also noted tarry stools, coffee-brown vomitus, epistaxis, gross hematuria, generalized ecchymoses and bleeding from the gums. On the following day the patient was seen by her home physician; the bleeding time was fourteen minutes, the hemoglobin content was 58 Gm. per hundred cubic centimeters and there were 13,700 white blood cells with 90 per cent polymorphonuclear leukocytes. Five hundred cc. of whole blood was administered. The bleeding gradually diminished. The patient was also given vitamin K, 5 mg. three times a day, intramuscularly and ascorbic acid 100 mg. twice a day intravenously. On April 30 a bleeding time of four minutes and hemoglobin level of 70 Gm. per hundred cubic centimeters was reported.

May 1, 1946. The patient was again seen by us and studied by Dr. Adolph Creskoff of the hematology department. At that time the hematologic findings were normal.

On May 3 the patient again noted profuse vaginal bleeding, had one bout of hematemesis, epistaxis and one tarry stool. It became necessary to pack the uterus and to administer three transfusions of 500 cc. of whole blood each between this date and May 8. When last seen May 25, 1946, the patient had apparently recovered entirely.

COMMENT

The etiology of this patient's bleeding is not clear, but it would seem that it was definitely related either to her reaction to penicillin or to the drugs used to combat this reaction. Proof of the cause of the bleeding could have been determined only by the experimental

133
947

administration of penicillin, Benadryl and Pyribenzamine, but such a procedure was not considered justifiable in view of the severity of the reaction which the patient had experienced.

The overall experience with Benadryl and Pyribenzamine in the treatment of urticaria due to penicillin is summarized in the accompanying table.

SUMMARY

Urticarial and other allergic reactions to penicillin at times constitute a serious bar to continuance of treatment with this compound. It is to be expected that as more persons receive repeated courses of penicillin a higher incidence of reactions will be observed. This, in our opinion, is another of the several reasons for the use of penicillin only on adequate medical indications.

The prognosis in any particular urticarial reaction to penicillin in regard to both the duration of the attack and the likelihood of its recurrence on readministration of penicillin is difficult to make. The antihistamine drugs, Benadryl and Pyribenzamine, are often of great value in the control of urticaria due to penicillin, and it is sometimes possible to continue the administration of penicillin by the simultaneous administration of one of them.

On the basis of general principles applicable to allergic reactions to drugs and of our experience with urticaria due to penicillin, the following scheme of management of such reactions is suggested:

1. Stop the administration of penicillin immediately, except possibly in occasional instances in which there is an immediate critical need on the part of the patient for the drug.

2. Administer Benadryl or Pyribenzamine in a dosage of 50 to 100 mg. three times a day by mouth to adult patients. The effectiveness or lack of effectiveness of such treatment will ordinarily become apparent within twelve hours. It may be necessary to administer the antihistamine compound as frequently as every four hours, around the clock. If the reaction to penicillin is severe or if it is desired to attempt its administration without interruption, the intravenous administration of Benadryl in a dosage of 5 to 10 mg. given slowly in 20 cc. isotonic sodium chloride solution is advised. The hypnotic effect of its intravenous administration is often decidedly startling, and we are not convinced that it does not possibly have some dangerous potentialities.

3. If the urticaria and accompanying symptoms subside, a test dose of 1,000 units of another manufacturer's penicillin may be administered intramuscularly, provided that facilities for the administration of epinephrine or of Benadryl intravenously are at hand. It is recommended that administration of an antihistamine drug by mouth be continued during this period.

4. If there is no reaction to the test dose within six hours, another dose of between 10,000 and 20,000 units may be given. Provided no reaction is evident within four hours, the administration of penicillin may be resumed in full therapeutic doses, with continued administration of the antihistamine compound.

5. The dosage of Benadryl or Pyribenzamine may be reduced gradually over the next two or three days. If the urticarial reaction recurs, the dose of antihistamine drug should be increased to the level previously found effective. However, in some patients it will be possible to discontinue such drugs entirely while continuing the administration of penicillin.

6. During the period of trial administration of penicillin, the use of compounds which delay the absorption of penicillin and maintain the level of penicillin in the serum for prolonged periods of time, e. g. penicillin in peanut oil and beeswax, is not advised. Penicillin in a form which will be rapidly excreted, should a reaction occur, is preferable.

7. Should readministration of penicillin be found impossible and should further penicillin therapy be considered highly advisable, as in syphilis, for instance, another attempt at readministration one or more months later may be successful. It is obvious that this should be carried out cautiously, with the patient under close observation.

8. The prospective wider availability of crystalline penicillin fractions and of improved antihistamine compounds should shortly make the knowledge of the etiology of reactions to penicillin more exact and the means of preventing and treating them more effective. The problem is one of increasing importance and deserves careful study by laboratory and clinical scientists and by manufacturers of penicillin.

THE PROBLEM OF VENOUS THROMBOSIS

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Of all complications relative to surgical operation, delivery or illness requiring medical management, venous thrombosis which results in permanently disabling venous obstruction or fatal pulmonary embolism stands as the most distressing.

It has only been within the past few years that the problem of venous thrombosis has been understood. Homans [1] and Ochsner and DeBakey [2] have divided intravascular clotting into two types: (1) a bland thrombosis or phlebothrombosis and (2) thrombophlebitis. With this division a more rational method of management may be instituted.

Because of a number of factors [3] the condition of intravascular clotting is apparently on the increase. The greater number of operative interventions that are now being performed and the increase in the magnitude of present day surgical practice are the most logical reasons. This view has been stressed by Matas.[4] It was formerly thought that this condition developed only in patients who had undergone surgical intervention, but the work of Burke [5] and others [6] has shown that it occurs almost as frequently in patients receiving medical treatment.

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ETIOLOGY

There are numerous factors which contribute to the development of venous thrombosis. Faure [7] found a greater instance during the winter months, especially when grippal infections were most prevalent. Also, more cases have been reported in Northern states than in Southern states. This fact could be attributed to the greater incidence of the infections of the upper part of the respiratory tract in the northern section of the country. Burke [5] emphasized a familial or constitutional tendency, and he noted the occurrence more frequently in asthenic, adipose types and in those persons who are hypothyroidic, overweight or weak muscled. Trosseau [8] noted the frequency of venous thrombosis that developed in patients with wasting diseases such as tuberculosis and especially cancer.

There are many plausible theories as to the development of venous thrombosis. The theory suggested by Frykholm [9] seems to have special merit: that when a patient lies in bed for some period of time the veins of the lower extremities are collapsed by the pressure of the leg against the mattress, with the result that the endothelial cells lining the venous wall may adhere to one another. The injured cells may become defective, roughened or torn loose, or thrombocytes and leukocytes may adhere to them; in either case these cells will act as a nidus for a thrombus. If this happens in a small vessel, it may easily be occluded. it is known that the leukocytes follow along the wall of the vessel, whereas the red blood cells are usually arranged in the middle of the stream.

Ochsner [10] suggested that vasospasm retards the flow of the blood in the lower extremities. The vasospasm may be due to the use of tobacco or to trauma such as that seen in fractures in which the vessel wall or surrounding tissues are injured. Circulatory retardation may be produced by posture, such as Fowler's position after abdominal surgery, in which the thighs are partially flexed on the abdomen and the legs on the thighs, causing a pooling of the blood in the popliteal veins. Immobility of the diaphragm caused by tight strapping of the abdomen after an abdominal operation and an increase in abdominal tension produced by intestinal gases may be factors. Ochsner and DeBakey [11] have also shown that after a surgical operation there are changes in the constitution of the blood which may be important in the occurrence of venous thrombosis. The changes in the plasma are an increase in its viscosity, hyperglobulinemia, hypoproteinemia and an increase in the fibrogen and calcium content. There are also changes in the formed elements of the blood, which consist of an increase in the number of thrombocytes and leukocytes and in their tendency to agglutinate.

Intravascular clotting is more frequently encountered in advancing age, as was shown by Allen and his co-workers,[12] who stated that 81 per cent of their cases were in patients over 40 years of age.

Barker and Priestley [13] of the Mayo Clinic in a review of 1,665 consecutive cases of postoperative venous thrombosis, pulmonary embolism and thrombophlebitis found that these complications occurred after 0.96 per cent of all operations and 2 per cent of all laparotomies and that this figure was increased to 3 per cent if the surgical procedure was performed on the female pelvis. It was further shown by these authors that patients with the following conditions were more prone to have these complications: carcinoma, disease of the peripheral veins, serious infections, cardiac diseases and hematic dyscrasias. These men stress the fact that patients with such conditions should have all precautionary measures instituted to prevent these complications when surgical intervention is contemplated.

In the opinion of most authorities [14] the site of the thrombus in phlebothrombosis is in the plantar veins or the veins of the calf muscles. In this case there is little or no inflammatory change in the vessel wall or in the vascular endothelium, but because of stasis and other factors previously mentioned there occurs the formation of a thrombus, which is similar to an extravascular clot in that it has a red color due to the presence of a high percentage of erythrocytes. Since the wall of the vessel is not involved the thrombus, which is exceedingly fragile, can easily become detached, especially when it gradually builds up and the end projects into a larger vessel. It is such a condition as this which frequently produces fatal pulmonary embolism when a patient first gets out of bed after an operation.

In thrombophlebitis there are maximum changes in the vessel wall which are produced by trauma to the wall, infection or, as Karsner [15] and Homans [16] have indicated, a perivenous lymphangitis. The deep portion of the femoral iliac system is the most frequently involved. Aschoff [17] considers that there is a deposition and agglutination of platelets on the injured vessel wall. Leukocytes and fibrin are also attached, producing a firm thrombus that is adherent to the wall. Such a thrombus as this is not so likely to become dislodged and produce pulmonary embolism.

CLINICAL MANIFESTATIONS

It is imperative that if adequate treatment is to be instituted, the clinical manifestations of each type of venous thrombosis be understood.

Phlebothrombosis.—As has been mentioned previously, a thrombus as a rule develops in the plantar veins or the veins of the calf muscles. From there it will extend into the popliteal and deep veins of the thighs and pelvis. At first there may be little or no evidence of involvement of the extremity. There may be only tenderness of the plantar surface of the foot or around the external malleolus or over the calf muscles. Veal and Hussey [18] stressed a localized tenderness over the veins of the lower part of the leg. Dorsal

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12. Allen, A. W.; Linton, R. R., and Donaldson, G. A.: Venous Thrombosis and Pulmonary Embolism, J. A. M. A. **128:** 397-403 (June 9) 1945.
13. Barker, N. W., Nygaard, K. K.; Walters, W., and Priestley, J. T.: A Statistical Study of Postoperative Venous Thrombosis and Pulmonary Embolism, Proc. Staff Meet., Mayo Clin. **15:** 769-773 (Dec. 4) 1940.
14. Homans, J.: Pulmonary Embolism Due to Quiet Venous Thromboses and Simulating Cardiac and Pulmonary Disease, New England J. Med. **229:** 309-314 (Aug. 19) 1943.
15. Karsner, H. T.: Human Pathology, Philadelphia, J. B. Lippincott Company, 1943.
16. Homans, J.: Deep Quiet Thrombosis in the Lower Limb, Surg., Gynec. & Obst. **79:** 70-82 (July) 1944.
17. Aschoff, L.: Thrombosis, in Lectures on Pathology, New York, Paul B. Hoeber, 1924.
18. Veal, J. R., and Hussey, H. H.: Surgery of the Deep Venous Thrombosis of the Lower Extremity, Surgery **17:** 218-231 (Feb.) 1945.

flexion of the foot with the leg extended (Homan's sign) was positive in a large percentage of patients in the University Hospital. An increase in the pulse rate is also a common observation. There may be no elevation of any importance in the temperature, unless it is produced by some concurrent condition. However, Allen, Linton and Donaldson [19] have stated that when a patient's chart shows a rise in the pulse rate, temperature and respiratory rate, it is strongly indicative of phlebothrombosis with a pulmonary embolism (figs. 1 and 2). The patient is often extremely nervous; he has an anxious look of impending danger. Edema of the foot and leg is seen in about 60 per cent of such cases, and when it is present postoperatively the patients should be carefully examined for indications of phlebothrombosis.

Sudden, sharp pain in the chest as a result of a pulmonary embolism was the first indication of phlebothrombosis in 41 per cent of patients in a series studied by Allen and his co-workers.[19] If the emboli are small, they may produce only pleuritis or substernal pain, faintness, coughing or bloody sputum; if they are massive, they may result in sudden death (figs. 3 and 4). Veal and Hussey [18] have shown that there is no period of safety from pulmonary emboli for a patient at any time from one day to four months after their formation if phlebothrombosis is present.

Allen, Linton and Donaldson [19] found that the lower lobes of the lungs were involved more frequently than the upper; as a matter of fact, in 96 per cent of their cases this observation assisted in making a differential diagnosis (figs. 5 and 6).

There is no satisfactory method of determining when the process has propagated far enough to involve the femoral or iliac veins. However, Homans [16] has suggested that cyanosis of the extremity, especially when it is tender and when the collateral veins of the skin are disturbed, practically always means that the deep vascular system is involved. It is in such conditions as this that phlebography [20] may be of assistance.

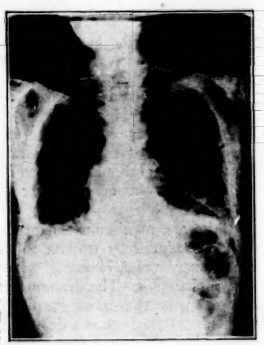

Fig. 1.—In a patient aged 68 with carcinoma of the prostate, the roentgenogram reveals a healing infarct at the base of the right lung and a recent infarct at the base of the left lung. Bilateral superficial femoral ligation is present.

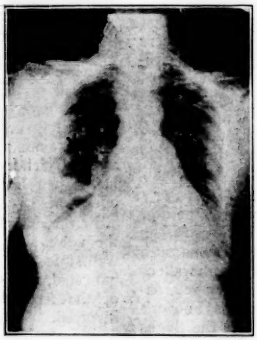

Fig. 2.—In a patient aged 64, with rheumatic heart disease, the roentgenogram shows a pulmonary embolism at the base of the right lung.

Fig. 3.—Lateral view of patient in figure 2 shows triangular area of infiltration typical of pulmonary embolism.

Thrombophlebitis.—There is much discussion at this time whether thrombophlebitis begins in the femoral-iliac system and extends to involve the deep venous system or whether it begins in the plantar and calf-muscle veins and extends to involve the femoral-iliac system. According to Homans,[16] Ochsner and DeBakey [3] and Fine and Sears,[21] it is the full, obstructing type of thrombosis accompanied by a decided perivascular inflammation with swelling of the inguinal lymph nodes. Since there is involvement of the wall of the vein, there is less likelihood of the formation of pulmonary emboli. When they do occur they are, as a rule, of the septic type. The thigh and the extremity are usually noticeably swollen and edematous, and when the superficial veins are dilated the iliac system is also involved. In about 5 per cent of the cases the process involves the superficial system, in which event there may be little edema. Since there is an infection present, there is an accompanying rise in temperature and in the leukocyte count. If the temperature curve is of the picket-fence type associated with chills, a suppurative condition will be found to be present. Pulsation of the arteries of the involved extremity will be of poor quality. The edema, pain and poor arterial pulsations were shown by Leriche,[22] Ochsner and DeBakey [2] to be caused by vasospasm.

TREATMENT

Prophylaxis of Venous Thrombosis.—The best form of treatment for venous thrombosis is prevention. It was mentioned earlier in this paper that patients manifesting certain conditions were more prone to the development of this complication; it is not amiss to mention again these conditions and express the need for caution when they are present: carcinoma, disease of the peripheral veins, cardiac diseases, serious infections, hematic dyscrasias and trauma.

In the University Hospital the residents and nursing staff are taught to examine carefully the lower extremities of all surgical patients or medically ill older

19. Allen, A. W.; Linton, R. R., and Donaldson, G. A.: Thrombosis and Embolism, Ann. Surg. **118:** 728-740 (Oct.) 1943.

20. Starr, A.; Frank, H. A., and Fine, J.: The Venographic Diagnosis of Thrombophlebitis of the Lower Extremities, J. A. M. A. **118:** 1192-1195 (April 4) 1942. DeBakey, M.; Schroeder, G. F., and Ochsner, A.: Significance of Phlebography in Phlebothrombosis, J. A. M. A. **123:** 738-744 (Nov. 20) 1943.

21. Fine, J., and Sears, J. B.: The Prophylaxis of Pulmonary Embolism by Division of the Femoral Vein, Ann. Surg. **114:** 801-812 (Nov.) 1941.

22. Leriche, R.: Sur l'importance de la périphlébite dans la genèse des accidents tardifs consécutifs aux obliterations veineuses, Bull. et mém. Soc. nat. de chir. **53:** 561-565 (April 16) 1927.

patients twice a day, to palpate the plantar surfaces of their feet and their calf muscles and to note the presence of edema or dilatation of the superficial veins and the presence of pain in the muscles of the sole or calf. Any postoperative pain in the chest is immediately investigated to be sure that it is not the result of an embolism from a silent venous thrombosis. The surgical patients and the older age group of medical patients who are required to remain in bed are instructed to move their lower extremities as much as possible. As Wangenstein said, a thousand times a day is not too much. De Takats and Fowler [23] and Ochsner and DeBakey [3] have stressed dorsal flexion and plantar flexion of the feet. The patient is encouraged to breathe deeply; tight abdominal bindings are not permitted because they prevent deep breathing. Postoperative distention should be prevented; dehydration should be combated with an adequate intake of fluids; sufficient heat should be applied to the body to prevent chilliness, which may produce vasospasm and influence venous thrombosis.

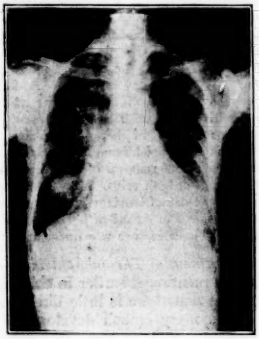

Fig. 4.—Arteriosclerotic heart disease with cardiac decompensation, in patient aged 55, gives roentgenologic evidence of a pulmonary infarct in the lower lobe of the right lung.

Fig. 5.—In a patient aged 53, with rheumatic cardiovascular disease, a left oblique view of the chest reveals a triangular area of infiltration typical of infarct in the lower lobe of the right lung.

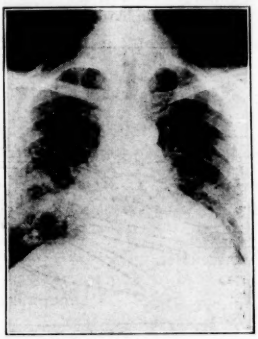

Fig. 6.—Roentgenogram of patient in figure 5 showing a pulmonary infarct in the lower lobe of the right lung.

Treatment of Phlebothrombosis.—When phlebothrombosis is present, or when a pulmonary embolus has developed from a silent thrombus, the most rational treatment is thrombectomy and ligation of the vein above the thrombus. This form of treatment was first used by Homans [1] and has been popularized by him and many others;[24] in fact, it is the accepted treatment for this serious condition.

Since the majority of thrombi have their origin in the veins of the feet or calf muscles, it is well to institute surgical treatment before the thrombus has propagated itself to involve the femoral or higher veins. By so doing the postoperative convalescence will be more satisfactory. Also, there will be less likelihood of the development of pulmonary emboli.

In early cases the site of ligation which we have found to be most advantageous is the superficial femoral below the profundi femoris. This site was popularized by Allen,[25] Linton and Donaldson.[19] In this area there are few muscle branches, the vein is readily accessible and there is a sufficient segment with which to work safely. Thrombi can easily be removed from the proximal and distal segments of the vein.

Operative Technic.—The technic which we employ operatively is essentially that which was advocated by Allen [19] and his co-workers [12] and Homans.[16] It is as follows:

Under local, Pentothal sodium or low spinal anesthesia a 4 inch (10 cm.) incision is made beginning below the crease of the groin and parallel to the pulsating femoral artery. The skin edges are carefully protected with towels. The incision is carried down to the vascular bundle; the femoral sheath is opened. The branches of the femoral nerve lie lateral to the femoral artery and vein. The femoral artery overlies the vein in this region. The artery is freed sufficiently, so it can be retracted laterally, and this is done gently. The superficial femoral vein now comes into view. If it is thrombosed it may adhere slightly to the femoral artery and surrounding tissues, in which event a higher ligation is done. The saphenous veins and venae profundae femoris should be identified. The superficial femoral vein is dissected out for a distance of about 3 cm. A strand of size 1 chromic catgut is placed under the proximal and distal ends and held with hemostats. The vein is incised transversely half through its diameter. Any clots which are present in the proximal or distal ends of the vein are removed with suction through a curved glass tube. Suction is then continued until free bleeding takes place from each end, if possible. However, it is more important that free bleeding develop from the proximal end. This may be encouraged by elevating the head of the operating table. After all clots have been removed the vein is ligated at each end and transected. A stitch suture of silk is also placed through each end of the vein. The wound is closed in layers in the usual manner.

If the superficial femoral vein is found to be thrombosed, the common femoral or the common iliac is exposed and ligated. It has been shown by numerous surgeons that it is unwise to ligate a diseased vessel wall, because clots in the proximal segment are difficult to remove or a thrombus may form again in the proximal segment and give rise to pulmonary emboli.

23. de Takats, G., and Fowler, E. F.: The Problem of Thrombo-Embolism, Surgery **17**: 153-177 (Feb.) 1945.
24. Ochsner, A., and DeBakey, M.: Therapy of Phlebothrombosis and Thrombophlebitis, Arch. Surg. **40**: 208-231 (Feb.) 1940.
25. Allen, A. W.: Thrombophlebitis and Pulmonary Embolism, Kentucky M. J. **42**: 160-165 (June) 1944.

Also, because the vein wall is so fragile an uncontrollable hemorrhage could result.

Bilateral superficial femoral ligation is recommended, especially if pulmonary embolism has occurred, in which case thrombectomy is advocated. Postoperative edema has not been of any importance. Elastic bandages applied to the feet and legs can be worn from two to six weeks if edema of any consequence develops.

Dicumarol, 3,3'-methylene-bis-(4-hydroxycoumarin), has been used after superficial ligation with daily, careful estimates of the prothrombin time. We have found no ill effects from its use, except in transurethral resection and in disease of the thyroid and liver; however, it has been reported that others [26] have. As a rule, the patient is ready to be dismissed from the hospital five or six days after superficial femoral ligation if other conditions permit.

We have found also that bilateral vertebral block using procaine hydrochloride and monobromosaligenin (Bromsalizol, a product of Hynson, Westcott & Dunning, Inc.) is useful in giving a better circulation to the extremity the first few days after femoral ligation. Usually, only one block is necessary.

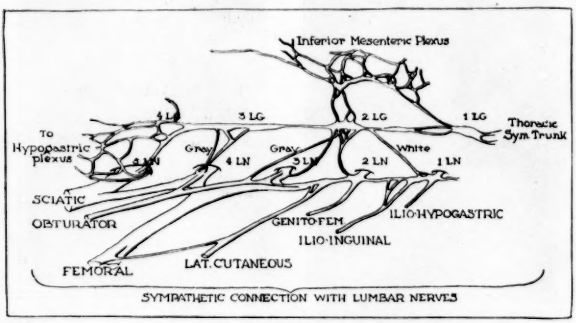

Fig. 7.—Anatomy of the lumbar sympathetic ganglions.

CASE 1.—*Phlebothrombosis—pulmonary embolism.* Mrs. E. W., aged 71 years, entered the hospital March 1, 1946 with a Pott's fracture of the right ankle. The fracture was reduced, and a plaster of paris cast was applied. On March 6 the patient was put in a wheel chair, at which time she suddenly noted a pain in the left side of her chest. Faintness and symptoms of shock occurred. The temperature was 101 F., the pulse rate 120 and the respiratory rate 30. Her left leg was normal; tenderness was present over the femoral vein of the right leg. A bilateral superficial femoral ligation with right thrombectomy was performed. A long clot was removed from the right superficial femoral vein. The patient's convalescence was uneventful.

CASE 2.—*Bilateral phlebothrombosis.* A. L., a white man aged 47, was first seen in the accident room. He stated that he had been walking more than usual for the past three days. The patient complained of pain on the plantar surfaces of his feet and in the calf muscles; a positive Homan's sign was present. Edema of his ankles was noticeable. The pulse rate was 100, the temperature 100 F.; the heart was normal and the blood pressure was 130 systolic and 80 diastolic. The patient seemed to have a feeling of impending danger. A diagnosis of bilateral phlebothrombosis was made. A bilateral superficial femoral ligation was performed under spinal anesthesia. Clots were removed from the distal end of each vein. The patient was discharged seven days later with no further trouble.

CASE 3.—*Phlebothrombosis—pulmonary embolism.* W. S., a white man aged 50, entered the hospital Oct. 1, 1945 for repair of a right inguinal hernia. On October 11 the patient noted the sudden development of pain in the left side of his chest. The temperature was 100.8 F., the pulse rate was 110. A roentgen examination of the chest revealed normal conditions. Homan's sign was positive on the left leg. The left ankle showed slight edema. On October 16 a second attack of pain occurred in the lower left side of his chest and in the right popliteal area; there was a positive Homan's sign with edema of the right ankle. The pulse rate was 108, the temperature 101 F. and the respiratory rate 30. A diagnosis of bilateral phlebothrombosis with pulmonary embolism was made. Superficial femoral ligation and thrombectomy were performed. The patient's convalescence was uneventful.

CASE 4.—*Bilateral phlebothrombosis—repeated pulmonary emboli.* Mrs. N. M., a white woman aged 44, was first admitted to the hospital July 1, 1945 with a history of repeated small pulmonary emboli. A diagnosis of left phlebothrombosis was made. A superficial femoral ligation was advised, but the patient refused to submit to the operative procedure. Her history and physical examination were not indicative of cardiac trouble, and she had not undergone previous surgical intervention. After treatment with Dicumarol the patient was discharged. On Oct. 9, 1945 the patient was readmitted to the hospital following a massive pulmonary embolism. A diagnosis of left phlebothrombosis was made; a positive Homans sign was present as well as edema of her left ankle. A bilateral superficial femoral ligation was performed with removal of clots from the distal ends of both veins. With the exception of the use of bandages for six weeks for treatment of edema of her ankles, the patient's convalescence was uneventful.

Treatment of Thrombophlebitis.—It was mentioned earlier in this discussion that there is little likelihood of pulmonary emboli developing in a patient with a well established thrombophlebitis. As Homans [16] wisely stated, the greater the swelling, the less danger of a soft detachable mass existing, and if embolism should occur, the veins of the other leg should be considered the offender. Previously the disability due to thrombophlebitis was relatively great; often the patients continued for the remainder of their lives with a swollen, tender leg that was prone to the development of trophic ulcers.

The most plausible theory in regard to the cause of the clinical manifestations in thrombophlebitis is vasospasm, as was suggested by Leriche.[22] Careful experimental and clinical work by Ochsner and DeBakey [2] has confirmed Leriche's observation. The vasospasm affects both the arterial and venous systems and in so doing disturbs the normal physiologic exchange of intravascular and perivascular fluids, thereby producing edema. When the vasospasm is relieved by sympathetic block of the regional sympathetic ganglion there is immediate improvement of the patient's condition. Within a few hours the pain disappears; the temperature rapidly returns to normal; good pulsations reappear in the dorsalis pedis and in the posterior tibial arteries. The skin, too, becomes soft as the edema begins to disappear.

When the lower extremity is involved, the first, second, third and fourth lumbar sympathetic ganglions are each blocked (fig. 7) with 10 cc. of a 1 per cent

26. Barker, N. W.; Cromer, H. E.; Hurn, M., and Waugh, J. M.: The Use of Dicumarol in the Prevention of Postoperative Thrombosis and Embolism, Surgery **17**: 207-214 (Feb.) 1945.

solution of procaine hydrochloride for the first to fourth ganglions and 10 cc. of monobromosaligenin each for the second and the third. The action of the procaine hydrochloride is immediate, and its effects will disappear within a number of hours. However, the action of the monobromosaligenin, while slower, will last from five to ten days.

When an upper extremity is involved, the most satisfactory method of treatment in our hands is the blocking of the first, second, third and fourth thoracic ganglions. Procaine hydrochloride alone is used. We [27] consider that monobromosaligenin [28] might be too irritating to the pleura. There have been no ill effects with the use of either of these solutions in a large series of cases of thrombophlebitis.

In addition to procaine blocking of the sympathetic ganglion the leg is elevated until the edema disappears, which usually occurs in from three to ten days. This is almost always true if treatment is instituted immediately after the condition develops. As the edema disappears active exercise is advised. If there is some persistence of the edema after the patient is allowed out of bed, an elastic stocking or bandage is worn for from two to six weeks. The bandage should incorporate the foot and leg up to and above the knee.

CASE 5.—*Thrombophlebitis of the left leg.* P. S., a white man aged 28, was admitted to the hospital Sept. 6, 1945 after a fracture of the left humerus and multiple pelvis fractures. On September 24 thrombophlebitis developed in the left leg of the patient. His thigh was greatly swollen and was painful. Pulsations in the arteries of the left foot were of poor quality. The temperature was 103 F. and the pulse rate was 110. On September 25 a paravertebral lumbar block was performed on the left side. The first, second, third and fourth lumbar ganglions were each injected with 10 cc. of a 1 per cent solution of procaine hydrochloride. The second and third ganglions were each injected with 10 cc. of monobromosaligenin. On September 27 good pulsations were observed in the dorsalis pedis and posterior tibial arteries. There were less edema and pain at that time. On September 30 the leg and foot were practically normal. On October 1 a paravertebral block using procaine hydrochloride and monobromosaligenin was performed as before. On October 5 no residual signs or symptoms were present in the previously affected leg.

CASE 6.—*Thrombophlebitis of the left leg.* Mrs. F. N., a white woman aged 64, was admitted to the hospital Aug. 8, 1945 with an inoperable carcinoma of the rectum. A permanent colostomy was performed, after which there developed a thrombophlebitis of the left leg. There was pronounced swelling of the foot, leg and thigh with poor pulsations in the arteries; the extremity was decidedly painful. The pulse rate was 112 and the temperature 103 F. A paravertebral lumbar block was performed, using procaine hydrochloride and monobromosaligenin in the same proportions as in case 5. This procedure was repeated in six days. After the first block the symptoms began to disappear; at the end of twelve days the extremity was symptom free.

CASE 7.—*Thrombophlebitis of the left leg.* Mrs. M. S., a white woman aged 55, was sent to the hospital with nodular toxic goiter, with cardiac arrhythmia and a pelvic mass. Forty-eight hours after her admission to the hospital thrombophlebitis developed in her left lower extremity. The temperature was 102 F., the pulse rate 110 and the blood pressure 170 systolic and 100 diastolic. The extremity was decidedly swollen, edematous and painful. The pulsations in the dorsalis pedis and posterior tibial arteries were extremely poor. The left lumbar sympathetic ganglions were injected, as in cases 5 and 6. Ten days later the temperature and pulse rate were normal. The leg was soft and pulsations were normal, with but little edema remaining.

27. Aycock, T. B., and Hendrick, J. W.: Sympathectomy for Peripheral Vascular Disease, Texas State J. Med., to be published.
28. Lee, F. C.; Macht, D. I., and Pierpont, R. Z.: The Use of Bromsalizol in Lengthening the Effect of a Sympathetic Nerve Block, Am. J. M. Sc. **209**: 314-324 (March) 1945.

SUMMARY

Venous thrombosis is a frequent complication and is seen in both medical and surgical patients. It occurs more frequently in the older age group of patients.

Patients who have cancer, cardiac diseases, serious infections, disease of the peripheral veins, hematic dyscrasias and trauma are more prone to have this complication develop.

In phlebothrombosis, the thrombus most frequently develops first in the plantar veins and in those of the calf muscle and propagates itself into the deep veins of the thigh and pelvis. Pulmonary embolism is a frequent complication.

Thrombophlebitis completely occludes the vein and usually begins in the deep veins of the thigh and pelvis. Pulmonary emboli are infrequent, but a painful, edematous leg often results unless appropriate treatment is administered early.

Thrombectomy and ligation of the affected vein above the thrombus is the rational treatment for phlebothrombosis.

In thrombophlebitis blocking of the sympathetic ganglions with procaine hydrochloride and monobromosaligenin (Bromsalizol) effects a cure.

HEPARIN IN THE TREATMENT OF THROMBOEMBOLIC DISEASE

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and
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Brooklyn

The purpose of this report is to present data regarding the rationale and effectiveness of heparin in the treatment of venous thromboembolic disease and to propose an improved method of heparinization, which is both safe and practical.

FUNCTIONAL PATHOLOGY

Although thromboses in the calf and plantar veins were observed for many years, the relationship between these minimal thromboses and fatal pulmonary emboli has been emphasized only in the past decade. It remained for Rössle,[1] Neumann [2] and Frykholm [3] to elaborate the anatomic development of pulmonary emboli and for Homans [4] and Bauer [5] to apply clinical and radiographic criteria by which aseptic deep calf thrombi could be recognized in their incipiency prior to the occurrence of pulmonary embolization. Based on the functional anatomy and clinical pathology of pulmonary embolization, Homans,[6] Bancroft,[7] Ochsner,[8]

From the Thromboembolic Disease Research Unit, Jewish Hospital.
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1. Rössle, R.: Ueber die Bedeutung und die Entstehung der Wadenvenenthrombosen, Virchows Arch. f. path. Anat. **360**: 180, 1937.
2. Neumann, R.: Ursprungszentren und Entwicklungsformen der Beinthrombose, Virchows Arch. f. path. Anat. **301**: 708, 1938.
3. Frykholm, R.: The Pathogenesis and Mechanical Prophylaxis of Venous Thrombosis, Surg., Gynec. & Obst. **71**: 307, 1940.
4. Homans, J.: Venous Thrombosis in the Lower Limbs: Its Relation to Pulmonary Embolism, Am. J. Surg. **38**: 316, 1937.
5. Bauer, G.: Venographic Study of Thromboembolic Problems, Acta chir. Scandinav. (supp. 61) **84**: 1, 1940.
6. Homans, J.: Circulatory Diseases of the Extremity, New York, The Macmillan Company, 1939; Varieties of Thrombophlebitis of Limbs: Their Origin, Course and Treatment, Am. J. Surg. **44**: 3, 1939.
7. Bancroft, F. W.: Proximal Ligation and Thrombectomy for Phlebothrombosis of Femoral and Iliac Veins, Ann. Surg. **121**: 175, 1945.
8. Ochsner, A.: Intravenous Clotting, Surgery **17**: 240, 1945.

Allen and his co-workers [9] and Bauer [10] then elaborated definitive principles of treatment for this condition.

It would be fitting at this point to trace the functional pathology of such a vascular accident. At the outset it must be admitted that many phases of the process are imperfectly understood and that many gaps exist

Fig. 1.—Phlebogram taken five months after femoral venous thrombosis treated by lumbar paravertebral block. Note the abnormal venous shunting through superficial channels and the failure of visualization of the deep venous system due to thrombotic occlusion of the femoral vein.

in our knowledge of spontaneous intravascular clotting. Our interest in the genesis and nature of intravascular clots was stimulated during our investigation of experimental human frostbite.[11] A study of the train of events in this condition by Greene,[12] and Rotnes and Kreyberg [13] revealed that there is a clumping of erythrocytes in the dilated arterioles for at least seventy-two hours after exposure. This clumping has been attributed to loss of plasma through the highly permeable vascular wall. As a result the red cells are stranded, silting up the blood vessels and forming what may be called a sludge. A related and revealing circumstance may be witnessed in the work of Knisely, Eliot and Bloch [14] on the formation of sludge in the blood during malaria and in traumatic shock. They have observed that the red cells become agglutinated to each other and form small clumps, as a result of which the flow of blood becomes sluggish and generalized thromboses supervene.

9. Allen, A. W.; Linton, R. R., and Donaldson, G. A.: Venous Thrombosis and Pulmonary Embolism: Further Experience with Thrombectomy and Femoral Vein Interruption, J. A. M. A. **128:** 397 (June 9) 1945.

10. Bauer, G.: Heparin in Venous Thrombosis, J. A. M. A. **131:** 196 (May 18) 1946.

11. Lange, K., and Loewe, L.: Subcutaneous Heparin in the Pitkin Menstruum for the Treatment of Experimental Human Frostbite, Surg., Gynec. & Obst. **82:** 256, 1946.

12. Greene, R.: Immediate Vascular Changes in True Frost-Bite, J. Path. & Bact. **55:** 259, 1943.

13. Rotnes, P. L., and Kreyberg, L.: Eine Methode zum experimentellen Nachweis von Stase mittels spezieller Präparate, Acta path. et microbiol. Scandinav., 1932, supp. 11, p. 162.

14. Knisely, M. H.; Eliot, T. S., and Bloch, E. H.: Sludged Blood in Traumatic Shock, Arch. Surg. **51:** 220 (Nov.-Dec.) 1945.

It is a well established fact that the blood platelet count rises rapidly in the immediate postoperative period, during which time the platelets become hyperadhesive.[15] Both phenomena attain their maximum peak about the tenth day after operative intervention. In addition to sludge formation and the changes in the number and quantities of platelets, the postoperative period is accompanied by a variable hemoconcentration, increased viscosity of plasma, hyperglobulinemia and increased fibrinogen content. Since all these factors contribute to clot formation, the stage is set for intravascular thrombosis anywhere in the body.

Although all the component elements for clot formation are present, we are still unaware of the precise catalyzing circumstance which initiates the chain reaction. In a statistical review of phlebothrombosis, one suggestive fact emerges, that a common denominator may be the slowing of the venous vascular stream, whether because of acute angulation or actual obstruction or by increased venous pressure secondary to either obesity or cardiac insufficiency. If one considers what part of the body would be most subject to slowing of the blood stream, for self-evident reasons the lower extremities must rank first. Thus during the post-

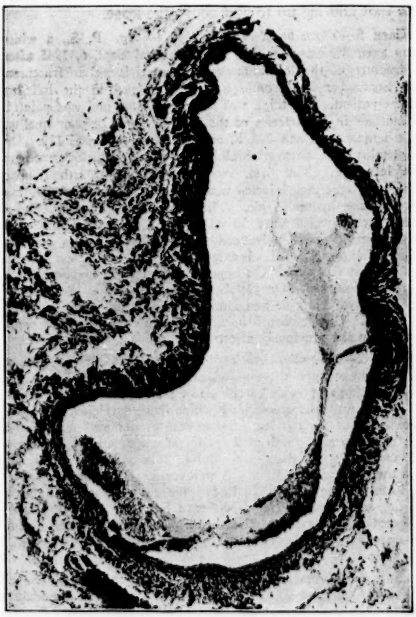

Fig. 2.—Photomicrograph of normal jugular vein of a rabbit, all coats intact; × 43.

operative period, in the presence of these chemical and physical changes in the blood, minimal intimal trauma in a venule of the lower extremity may well initiate a local intravascular thrombosis.

15. MacKay, W.: Blood-Platelet: Its Clinical Significance, Quart. J. Med. **24:** 285, 1931. Wright, H. P.: Adhesiveness of Blood Platelets in Normal Subjects with Varying Concentrations of Anti-Coagulants, J. Path. & Bact. **53:** 255, 1941; Changes in Adhesiveness of Blood Platelets Following Parturition and Surgical Operations, ibid. **54:** 461, 1942.

The original thrombotic process usually starts in the smaller vessels in the muscular portions of the calf and, less frequently, in the plantar veins. The clot progresses and soon reaches a larger vessel, into which it extends and grows. The clot is at first attached only to the venule and only later engages the

Fig. 3.—Nonheparinized control: jugular vein of a rabbit six days after trauma, presenting a visible and palpable clot.

wall of the larger vessel. As the clot propagates it consists in the main of the red cell clot which waves freely in the vascular stream. This clot contains minute amounts of fibrin and is but one stage removed from the sludges observed in experimental frostbite and in malaria.

We have reproduced this intermediate stage in the laboratory—a palpable, visible clot, which, however, is so loosely put together that it disintegrates readily. As the clot grows, the propagating proximal end represents all the stages previously described. It is now that the clot is most dangerous, for it may separate at any time, either spontaneously or as the result of some muscular exertion, such as straining at stool or getting out of bed. If the clot does not become detached it slowly becomes organized, attaching itself to the vessel wall during the process. During the stage of clot propagation immediately adjacent tributaries and collateral vessels are also involved; consequently, when organization with either obliteration or recanalization occurs there is a shunting of the venous stream to superficial vessels incapable of bearing the burden. This bizarre venous shunting is readily seen in postthrombotic phlebograms (fig. 1). Although we have been discussing so-called aseptic phlebothrombosis, essentially the same process occurs in the infective thrombophlebitis, in which the most proximal portion of the clot resembles the noninfective variety.

In either the aseptic or septic types of thrombophlebitis, if the process continues long enough, a periphlebitis occurs which involves the adjacent perivenous lymphatics. Lymphatic fluid is capable of coagulating, and it is quite conceivable that postphlebitic edema may be due in great part to consequent obstruction of the return lymphatic flow of an extremity.

RATIONALE

It is obvious that, in the situations which we have described, termination of the progressive thrombotic process would be ideal. To the best of our present knowledge the anticoagulants appear most suited for this purpose. Of these, we have been impressed by the properties of heparin. The accepted knowledge concerning the mechanism of action of this agent is as follows: (1) it prevents, with the aid of a plasma cofactor, the conversion of prothrombin to thrombin; (2) it forms a strong antithrombin in conjunction with serum albumin, and (3) it prevents the formation of thromboplastin from platelets. These properties predicate the fact that a clot, regardless of what stage it is in, cannot propagate in the presence of heparin. However, what happens to the clot which is already present?

The action of heparin has been studied mostly in vitro. Animal experiments in our laboratory [16] have yielded the following data:

1. Red cell clots which are not organized and which contain a minute amount of fibrin (sludge stage) dis-

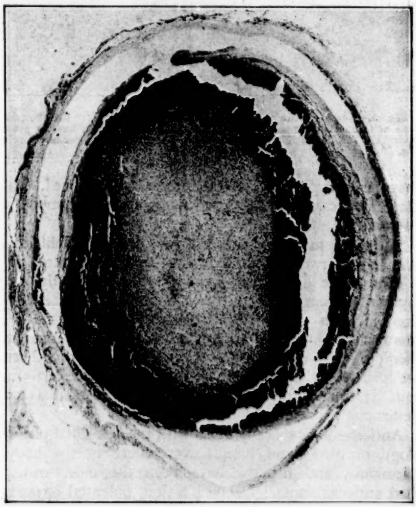

Fig. 4.—Photomicrograph of section of jugular vein (fig. 3) with all coats intact. The blood presents no classic evidence of clot and is present as particulate masses with a minimum of fibrin (sludge); magnification slightly reduced from × 30.

appear completely under heparin therapy (figs. 2, 3, 4, 5 and 6).

16. Our method of consistently producing clots in rabbits has been to traumatize the jugular vein with twenty hammer strokes after it has been ligated proximally. This work will be fully reported in a forthcoming paper.

133
947

2. Heparin therapy maintains patent adjacent collaterals and tributaries, which ordinarily would become involved in the thrombotic occlusive process. These compensatory collaterals often become as large as the originally occluded vessel (fig. 7). This phenomenon has not been observed in control animals (fig. 8). It

Fig. 5.—Jugular vein of rabbit six days after trauma with fourteen days of heparinization superadded. The wall is thickened, but no gross evidence of clot is visible. Compare with the control nonheparinized vein (fig. 3).

may be assumed, though not necessarily proved, that these processes also occur in obstructed lymphatic vessels.

Although methods of treatment of thrombophlebitis are legion, two major thoughts have dominated the clinical scene during the past five years; namely, the ligation of veins and anticoagulant therapy. The ligation of veins need not be discussed here, since the literature abounds in articles advocating this form of therapy. Our contrary views on the matter have been set forth elsewhere.[17] We do not believe that bilateral vein ligation as recommended can be classified as an innocuous procedure.

Anticoagulant therapy deals with the abnormal physiology of blood and lymph everywhere in the body. Dicumarol and heparin have been the most widely used anticoagulants. Delayed action, potential hazards and the requisite complicated but indispensable laboratory procedures militate against Dicumarol as the anticoagulant of choice. The action of heparin on the other hand is prompt and readily controlled and administered. Heretofore, the major drawbacks to the administration of heparin have been the necessity of maintaining adequate anticoagulant levels by a continuous intravenous drip method with its accompanying discomforts and inconveniences to the patient and physician alike and the inordinate quantity of the drug required, with its attendant expense.

These objections have been overcome by incorporating the drug in the Pitkin menstruum,[18] which was developed to retard the rate of release of water-soluble drugs injected subcutaneously or intramuscularly.

Heparin/Pitkin menstruum is a preparation of various amounts of heparin with or without vasoconstrictor drugs dissolved in the Pitkin menstruum, which is composed of gelatin, dextrose and glacial acetic acid

TABLE 1.—*Heparin/Pitkin Menstruum Formulas*

	With Vaso-constrictors		Without Vaso-constrictors	
Crystalline sodium salt of heparin, mg.	500.0	200.0	800.0	200.0
Epinephrine hydrochloride, mg.	1.0	1.0	0	0
Ephedrine sulfate, mg.	25.0	25.0	0	0
Chlorobutanol, mg.	0.5	0.5	0.5	0.5
Eucupin * dihydrochloride, mg.	1.0	1.0	1.0	1.0
Pitkin menstruum, cc.	3.0	2.0	3.0	2.0

* Contains 1 per cent eucupin base, 3 per cent ethylaminobenzoate and 5 per cent benzyl alcohol in oil of sweet almond.

in definite proportions which vary according to the amount of heparin. The various formulas[19] (table 1) were devised so that the dosage might be varied as indicated in the treatment of the individual patient.

In general the anticoagulant action of heparin in the menstruum combined with vasoconstrictor drugs is

Fig. 6.—Photomicrograph of section of jugular vein (fig. 5) with all coats intact. No evidence of clot or fibrin. Compare with figure 4.

more prolonged than that of the same amount of heparin in the menstruum without the vasoconstrictor

17. Loewe, L.; Rosenblatt, P., and Hirsch, E.: Venous Thromboembolic Disease, J. A. M. A. **130**: 386 (Feb. 16) 1946.

18. Loewe, L.; Rosenblatt, P., and Lederer, M.: A New Method of Administering Heparin, Proc. Soc. Exper. Biol. & Med. **50**: 53, 1942. Loewe, L., and Rosenblatt, P.: A New Practical Method for Subcutaneous Administration of Heparin: Preliminary Report, Am. J. M. Sc. **208**: 54, 1944.

19. Prepared and distributed by William R. Warner & Co., Inc., New York.

drugs. In thromboembolic venous disease heparin with vasoconstrictor drugs is customarily employed.

Heparin/Pitkin menstruum given as a simple deep subcutaneous deposit every two or three days supplants the technically more difficult intravenous administration of the aqueous solution. Thus, the total requirement

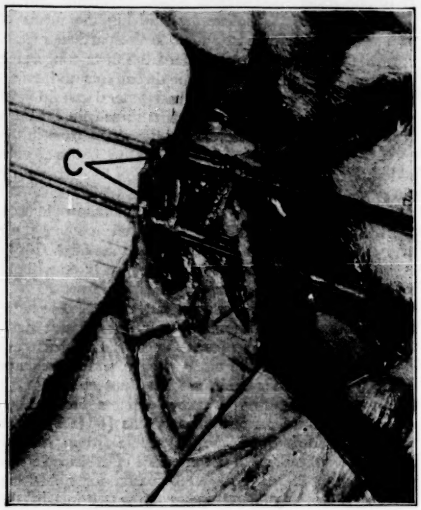

Fig. 7.—Jugular vein of rabbit fourteen days after trauma with fourteen days of heparinization superadded. Minimal, if any, blood flow through the traumatized vessels (*V*). Note the dilated extensive compensatory collaterals (*C*). Compare with the control nonheparinized vein (fig. 8).

of heparin for a given patient is greatly curtailed, and the overall cost of the treatment program is materially reduced.

The technic of administration of heparin in the Pitkin menstruum, its clinical use and the method of following the patient's clinical course has already been presented in great detail in previous communications.[20] The one objection to the preparation, the pain factor so disturbing to the patient, has now been overcome by careful buffering which has made the p_H of the gel more physiologically acceptable.

CLINICAL OBSERVATIONS

The clinical deportment of heparin in the Pitkin menstruum has been observed in 168 patients[21] representative of all forms of venous thromboembolic disease (table 2). The results continue to be eminently satisfactory as judged by the effective control of pulmonary embolization, the prompt amelioration of pain and discomfort, the rapid recession of edema, the reduction in morbidity, the acceleration of convalescence and the virtual absence of residual edema, particularly when patients are treated without delay.

Most informative are the statistics with respect to the patients who had pulmonary embolization. There were 4 fatalities in this group, representing over 2 per cent of the entire series of 168 patients and over 6 per cent of the 63 patients who had suffered from one to six episodes of pulmonary embolization. These 4 treatment failures occurred early in our experience, before the optimum treatment program had been established.

The span of treatment for uncomplicated thrombophlebitis and/or phlebothrombosis is ten days to two

TABLE 2.—*Heparin Treatment* of One Hundred and Sixty-Eight Consecutive Patients with Venous Thromboembolic Disease*

Classification	No. of Patients	No. of Patients with Pulmonary Embolization	Deaths Due to Pulmonary Embolization
Postoperative thrombophlebitis and/or phlebothrombosis	75	31	3
Thrombophlebitis and/or phlebothrombosis, miscellaneous †	51	23	0
Postpartum thrombophlebitis	21	5	0
Postinfectious thrombophlebitis	9	0	0
Post-traumatic thrombophlebitis	7	4	1
Migrating thrombophlebitis	5	0	0
Totals	168	63	4 (2.4%)‡

* Administered in Pitkin menstruum as a deep subcutaneous deposit.
† Occurring without ascertainable exciting cause (thrombophiles) or as a complication of carcinoma or varicose veins.
‡ Four treatment failures, 2.4 per cent of entire series and 6.3 per cent of 63 patients with pulmonary embolization, occurred before the optimum treatment program was established.

Fig. 8.—Nonheparinized control: jugular vein of a rabbit fourteen days after trauma. The vessel is thickened and gray and contains a solid, palpable clot.

weeks. For patients with pulmonary embolization an additional week or two of therapy is required, depending on the extent of pulmonary infarction. In any event the full effect of heparin must be present at the time when the patient is first allowed out of bed. The consistently favorable response has fully justified our conservative plan of therapy.

20. Footnotes 17 and 18.
21. This series of cases was recruited principally from the Departments of Surgery, Medicine, Gynecology and Obstetrics of the Jewish Hospital. We wish to thank them for referring this clinical material.

Papaverine is used concomitantly in liberal dosage; 1 to 1½ grains (0.06 to 0.09 Gm.) every four hours intramuscularly or intravenously, then, later, maintenance dosages by mouth. The use of digitalis is discouraged because of its possible thromboplastic influence, and smoking is strictly forbidden. Paravertebral block, although optional and effective in arterial occlusion, is not incorporated in the treatment program for venous thromboembolic disease, since we have observed that the complicating vasospasm in this disorder disappears almost immediately after the conjoint use of the subcutaneous heparin/Pitkin menstruum and papaverine.

Although truly comparative statistics are still not available, a review of our clinical material considered in the light of our animal experimentation continues to make subcutaneous heparin, which has supplanted ligation of the proximal veins in our clinic, the treatment of choice in venous thromboembolic disease.

SUMMARY AND CONCLUSIONS

1. The functional pathology of intravascular clotting has been outlined as a basis for evaluating the treatment of thromboembolic disease.

2. Heparin plays a vital role in arresting the progress of intravascular thrombosis and promotes restoration of the vascular stream.

3. Heparin in the Pitkin menstruum was employed in the treatment of 168 consecutive patients with venous thromboembolic disease with satisfactory results.

VENOUS THROMBOSIS AND PULMONARY EMBOLISM

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This communication will present the experience at the Massachusetts General Hospital with thrombosis and embolism up to June 1946. Previous reports have stressed the importance of this syndrome and have called attention to the diagnostic criteria.[1] The safety of interruption of the femoral veins in the treatment of this disorder has been demonstrated. We wish now to record our present views on the subject including a controlled study on the use of Dicumarol.

PROPHYLAXIS

Prevention of thrombus formation in the deep veins of the legs is, in fact, the basic principle on which investigators in this field have been working for many decades. Progress has been slow, yet through a coordination of ideas much has been accomplished along these lines. Inasmuch as thrombosis within the veins is most apt to occur as a complication of illness or operative intervention, the opportunity for prophylaxis against this additional hazard to the patient is often overlooked or for obvious reasons is not easily carried out. Trauma to and stasis in the veins may be avoided in many instances, but often the actual disease or injury precludes certain forms of prophylactic treatment which have been found useful under more suitable conditions. It is our belief that various types of patients can be protected against embolism by utilizing the forms of preventive measures best suited to the particular case.

In the first place, we must face the facts concerning the frequency and seriousness of thrombosis and embolism with reference to the age and general condition of the patient. Our records show that these complications are much less likely to develop in the young than in the aged. Also, the more debilitated the patient, with added restrictions as regards mobility of the extremities plus trauma and infection, the more likely it is that thrombosis will occur. That all forms of prophylaxis are not adaptable to all patients seems obvious; yet many reports on the subject imply that one method may be applied regardless of the age factor and often without regard to the disease or injury under treatment.

Dicumarol can be safely used in a considerable number of patients. As shown by our comparative data, it is effective in the prevention of thrombosis and embolism even with the small dosage which we have tried. On the other hand, we have not considered it safe to use this drug in many patients for reasons shown in our table of contraindications (table 1). We have withheld it from the older age group on the basis of complications in the presence of arteriosclerosis after the use of heparin. Our reason for not using Dicumarol in the younger age group was primarily the infrequency of thrombosis and of fatal embolism in patients under 40 years of age. We admit that we could with safety give the drug to many of the younger patients and that we would use it as a part of the treatment of thrombosis and embolism in any event.

It seems to us that the age group between 40 and 65 is the correct one in which to use Dicumarol for the prevention of thrombosis. In this group there are many patients with serious ailments who are apt to be restricted in their activities by either their disease or the therapeutic measures indicated. In many of these patients, if left untreated, there will develop thrombosis of the veins of the legs, and many will have pulmonary emboli—some of which will be fatal. In those who recover the convalescence will be prolonged. Unless there is a contraindication to the use of Dicumarol, or unless laboratory control of the prothrombin time is not available, the majority of this group of patients can be protected from thrombosis and embolism by using small doses of this drug postoperatively.

In those patients beyond the age of 65 and in selected prematurely old or debilitated persons we believe that the best method of protection against thrombosis and embolism is interruption of the superficial femoral veins. It took considerable courage to adopt this point of view, but we were so impressed with the complete lack of circulatory or lymphatic disturbance after the interruption of the normal superficial femoral vein that we now have no hesitation in advocating this procedure as a method of choice (table 2). More instances of fatal embolism without warning occur in this older age group. We have no proof that phlebothrombosis is more likely to develop than thrombophlebitis. It

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1. Allen, A. W.; Linton, R. R., and Donaldson, G. A.: Thrombosis and Embolism, Ann. Surg. **118**: 728-740, 1943; Venous Thrombosis and Pulmonary Embolism, J. A. M. A. **128**: 397-403 (June 9) 1945. Allen, A. W.: Thrombosis and Embolism, Bull. New York Acad. Med. **22**: 169-184 (April) 1946.

appears, however, that a much higher percentage of the older patients have enough thrombus detach at one time to cause death than do the younger ones. True phlegmasia alba dolens, as it is seen in young convalescents, is much more infrequent in the aged. Since the bland type of thrombosis is so much more dangerous from the standpoint of embolism than is the inflammatory type, we have a further indication for vigorous prophylactic measures in the older group of patients.

In patients under the age of 40 we consider that there is less need for the routine use of interruption of the femoral veins or Dicumarol therapy as prophylactic measures against thrombosis, if the clinician keeps alert and institutes proper treatment when indications arise. It is helpful to carry out systematic active exercises of the legs and to avoid tight dressings and abdominal distention. Gravity to keep the leg veins empty and the use of pressure bandages on the legs are helpful adjuncts. In addition, one must carefully examine the legs twice a day for signs of swelling, dilatation of the superficial veins and tenderness along the course of the deep veins. Also, one must carefully evaluate any pain or discomfort in the legs as well as in the chest. The clinical chart is of importance, since the simultaneous recording of a slight elevation of temperature, pulse rate and respiratory rate gives a clue to phlebothrombosis, even when there are no signs in the legs or pain in the chest. Routine use of the drug in this age group would put a heavy strain on the laboratory, which would outweigh its advantages. Routine prophylactic interruption of the superficial veins, would put an unwarranted burden on the operating rooms.

Early ambulation has been used in our hospital for a number of years and has many advantages in approximately one half of the patients treated by surgical means. With wounds made on an anatomic basis and with the use of nonabsorbable sutures we can avoid some of the usual complications of convalescence. Patients do not get soft from long rest in bed and are able to return to their regular occupations at a much earlier date. Normal bodily functions are enhanced and many hospital days are saved. It was felt that early ambulation might lower the incidence of thrombosis and embolism. There is considerable evidence against this and little to support it.[2] Perhaps the chief factor in our disappointment in this regard is due to the misinterpretation of the term early ambulation. This should mean that the patient actually gets out of bed and walks and then lies down again. Instead of this, we find these patients sitting in a chair with their feet on the floor after having actually been lifted there from the bed by a well meaning orderly. Stasis in the leg veins, being increased by such a maneuver, may well offset any other beneficial effect that early rising may have. We now believe that, unless patients can carry out the muscular activity needed to keep the leg veins empty, early risers should be protected from thrombosis and embolism according to the principles outlined for the various age groups.

THERAPY

Treatment of thrombosis of the deep veins of the legs, with or without pulmonary infarct, has been under discussion from several points of view. In the first place, one must differentiate between phlebothrombosis and thrombophlebitis. In the bland type of thrombosis one has little opportunity for therapeutic measures that are effective other than interruption of the deep vein—preferably above the thrombus. The diagnosis is often made after infarct has taken place. Too often such a complication is unsuspected, and the patient may die suddenly from massive embolism when otherwise making a satisfactory recovery. In such patients there may be little to indicate the existence of thrombosis. On careful examination, however, there can usually be found sufficient evidence to warrant the institution of proper therapy. Unfortunately, such minor signs as dilatation of the superficial veins of the foot, slight swelling of the extremity or a concomitant slight rise in temperature, pulse rate and respiratory rate are often overlooked. Even sudden pain in the chest may be attributed to atelectasis, pleurisy or pneumonitis, when in fact infarct has occurred.

TABLE 1.—*Reasons for Contraindication of Dicumarol Therapy*

Reason	Percentage
Hospitalized for minor procedures	47.5
Admitted for study, no surgical operation	18.0
Disease of the liver	5.5
Hypertension	7.0
Disease requiring chest surgery	6.0
Plasma prothrombin determination above 25 seconds	6.5
Hyperthyroidism	3.5
Excessive bleeding at operation	2.5
Diabetes	2.0
Arthritic patients taking acetylsalicylic acid	1.5
Total	100.0

Of 985 patients between the ages of 40 and 65 who were admitted to the East Surgical Service of the Massachusetts General Hospital from Jan. 1, 1945 to June 1, 1946 Dicumarol was received by 162 (16.5 per cent). In the remaining 823 patients, use of the drug was contraindicated.

TABLE 2.—*Incidence of Therapeutic and Prophylactic Interruption of the Femoral Vein in 1,281 Cases from 1937 to June, 1946*

	Therapeutic	Prophylactic		Total
1937 to 1942	202	0	0%	202
1943	150	15	9%	165
1944	208	72	26%	280
1945	241	178	45%	392
1946 (June 1)	150	92	38%	242
Total	924	357		1,281

Thrombophlebitis is a term which should be used only when inflammation in and about the veins and lymphatics produces pain, swelling, tenderness and fever. This type of thrombosis may come on quickly, and in its fulminating form is known as phlegmasia alba dolens. If such is the case infarct is less apt to occur, and if it does it may not be massive in character. It is justifiable to treat patients with such types of thrombosis by procaine block of the lumbar sympathetic nerves,[3] elevation, the local application of heat and even activity. The anticoagulant drugs are valuable in the treatment of such conditions, inasmuch as they prevent spread of the thrombotic process. In this type of thrombosis interruption of the femoral veins is justifiable only in the early phases of the disease. Ligation of the vena cava is indicated if such a thrombosis is the cause of repeated septic infarcts.

Between phlebothrombosis and thrombophlebitis there are all gradations of the disease. In many

2. Blodgett, J. B., and Beattie, E. J.: Early Postoperative Rising: A Statistical Study of Hospital Complications, Surg., Gynec. & Obst. **82**: 485-489 (April) 1946.

3. Ochsner, A., and DeBakey, M.: Thrombophlebitis: Role of Vasospasm in the Production of Clinical Manifestations, J. A. M. A. **114**: 117-124 (Jan. 13) 1940.

patients thromboses which are apparently bland in the beginning will gradually develop into thrombophlebitis. This change in character may not be a real one, since the inflammatory element may be present in the beginning of a bland thrombus. The gradual, insidious onset as opposed to the sudden development of the fulminating inflammatory type of the disease may, in fact, be dependent on the virulence of the micro-organisms associated with the infection. That some cases of phlebothrombosis remain as such is certain. Most of the sudden fatalities from massive embolus occur while the thrombus is bland and not held firmly within the vein by inflammation. It has been obvious to us, in our climate at least, that in the majority of survivors from phlebothrombosis there develops a true inflammatory reaction in and about the involved veins if treated expectantly.

Phlebotomy and thrombectomy with interruption of the superficial femoral veins not only prevents fatal embolism but shortens the course of thrombophlebitis. Most of our patients have this operation performed before any signs of inflammation are apparent, and in many of these thrombophlebitis fails to develop. In fact, many of them have venous interruption performed before the thrombus has reached the level of the common femoral vein. Some of them, however, do run a mild course of thrombophlebitis after the interruption of the femoral veins. A small percentage of patients continue to have infarcts after this operation. Patients who have pain, tenderness and swelling in the leg after interruption of the veins and those who continue to have infarcts are treated further by procaine block of the lumbar sympathetic ganglions and by anticoagulants.

The treatment of phlebothrombosis and early thrombophlebitis by anticoagulants alone has not recently been used in our clinic. Earlier experiences revealed that such management in our hands was unsatisfactory.[4] Some patients did well on heparin therapy as long as the drug was continued. However, it was found that the process flared again shortly after heparinization was stopped, and 1 such patient succumbed to massive embolus during this treatment. It therefore seems illogical to us to use this method of treatment against this disease unless it has been preceded by interruption of the femoral veins.

OPERATIVE TECHNIC

After observation of repeated instances of the lack of complete understanding in regard to our conception of the way and manner in which interruption of the femoral vein should be carried out, we feel justified in emphasizing the details of operative technic. The dangers of interruption of the common femoral and saphenous veins have been stressed by Dennis,[5] who reported an instance of fulminating edema subsequent to such a procedure. The patient's leg was saved by liberal incisions down through the fascia to the muscles. In addition to this danger we have pointed out the increased difficulties of exposure of this segment of vein, due to its short course and numerous muscular branches. Should one find that the vena profunda femoris is thrombosed at the time of interruption of the superficial femoral vein, the ligature can be placed around the profunda with greater ease than an interruption of the common femoral itself could be performed. This ligature adequately eliminates the vena profunda femoris as a source of subsequent emboli and, when combined with proper interruption of the superficial femoral vein, accomplishes the same result as does interruption of the common femoral vein.

In our opinion interruption of the iliac veins as advocated at one time by Homans[6] is not often indicated. This attack on the problem is theoretically sound, since the ligature can more often be placed around the vein above the thrombus. Practically, however, it has many disadvantages. Particularly hazardous is the necessity for two major operations, which must be performed under a form of anesthesia which is more dangerous than local infiltration on these exceedingly ill patients. It may be argued that only one iliac vein need be tied if the other is uninvolved. If both iliac veins should need interruption on the basis of septic thrombosis with repeated infarcts, it seems to us that ligature of the inferior vena cava is a better procedure. Our experience would indicate that such an operation is seldom necessary, since the results from phlebotomy and thrombectomy through the superficial femoral vein have proved to be satisfactory in such a large number of cases.

One of us (R. R. L.) has performed this operation on 13 patients. In this group it was not found necessary to interrupt the ovarian veins, but this added step should be considered, as has been pointed out by Collins and associates.[7] In 2 patients in this group there has developed chronic ulcer of the lower legs, and a third one has had a recurrence of ulcerations, which incidentally have responded to femoral vein interruption. These experiences have made us hesitate to interrupt the inferior vena cava except in the unusual and infrequent case of septic thrombosis with pulmonary infarction.

It is important that the lymphatic vessels in the region of operative intervention be interfered with as little as possible. This is one of the chief reasons for avoiding an incision that transects the lymph channels. Transverse or oblique wounds are certain to interrupt lymphatic vessels and should never be used to expose the deep femoral vessels. The most persistent and disabling edema that we have seen after interruption of the femoral veins occurred in a patient operated on in another hospital through a 6 inch (15 cm.) oblique incision below the crease of the groin. In spite of the natural lines of cleavage in the skin being transverse or oblique in this region, it is difficult when such an incision is used not to carry the dissection across many of the lymphatic vessels.

Another important disadvantage to the oblique or transverse incision is that it handicaps the surgeon in the exposure of the femoral vessels; if severe bleeding is encountered, due to the accidental tearing of one of the tributaries of the femoral vein, serious and irreparable damage may be done to the femoral artery in attempting to control the hemorrhage. One of us (R. R. L.) has recently been consulted in such a case at another hospital. The surgeon, using a transverse

4. Welch, C. E., and Faxon, H. H.: Thrombophlebitis and Pulmonary Embolism, J. A. M. A. **117**: 1502-1508 (Nov. 1) 1941.

5. Dennis, C.: Disaster Following Femoral Vein Ligation for Thrombophlebitis: Relief by Fasciotomy; Clinical Case of Renal Impairment Following Crush Injury, Surgery **17**: 264-269 (Feb.) 1945.

6. Homans, J.: Deep Quiet Venous Thrombosis in the Lower Limb, Surg., Gynec. & Obst. **79**: 70-82 (July) 1944.

7. Collins, C. G.; Jones, J. R., and Nelson, E. W.: Surgical Treatment of Pelvic Thrombophlebitis; Ligation of Inferior Vena Cava and Ovarian Veins; a Preliminary Report, New Orleans M. & S. J. **95**: 324-329 (Jan.) 1943.

incision, encountered serious venous bleeding during the operation. Before it was controlled both the superficial and deep femoral arteries were ligated to save the patient's life from hemorrhage. The circulation of the extremity had been irreparably damaged when first seen, necessitating a low thigh amputation at a later date. The use of a vertical incision will prevent such catastrophes, since with it more complete exposure of the femoral vessels is obtained; and if accidental hemorrhage is encountered it can be more readily controlled, if necessary by further extension of the incision. The use of this type of incision is one of the cardinal principles in the surgery of major blood vessels of the extremities and it is our opinion that its use in interruptions of the femoral veins cannot be overemphasized.

An incision about 8 cm. in length from the crease of the groin over the pulsating artery along the course of the vessels distally allows the vascular bundle to be exposed with minimal lateral dissection. The lymphatic vessels can be retracted laterally, and few of them need be transected. The exact center of such an incision leads to the uppermost segment of the superficial femoral vein. The junction of the superficial and profunda femoris is identified by a bulge in the superficial femoral just distal to this bifurcation (fig. 1). The artery overlies the vein in this region and is easily dissected free and held out of the way. It should not

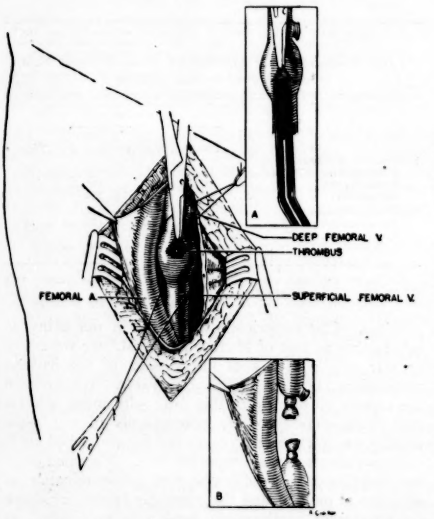

Fig. 1.—An artist's drawing to show the exposure of the superficial femoral vein with thrombectomy. Note the vertical incision used; the dilatation of the proximal end of the superficial femoral vein with the deep femoral vein joining it just above this bulge; the retraction of the femoral artery without completely isolating it. Inset *A* shows aspiration of the thrombus with a glass cannula. Inset *B* shows the completely divided superficial femoral vein. Each end is doubly ligated with a ligature and a transfixion suture of cotton and silk.

be isolated completely and retracted with ligatures or rubber tubing, since 1 case of thrombosis of the femoral artery due to rupturing the arterial wall, with resultant gangrene, has been seen in another hospital in which this method was used. The superficial vein is usually free of branches over its uppermost 1 to 2 cm. This enhances the isolation of this segment so that ligatures are easily placed at the upper and lower levels of the freed portion of the vein. It is important to open the

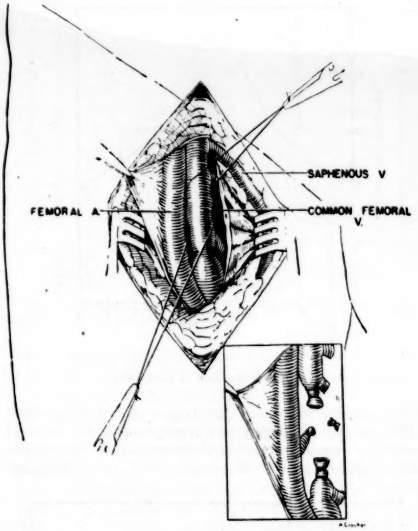

Fig. 2.—An artist's drawing to show the exposure of the common femoral vein proximal to junction of the superficial femoral and deep femoral veins. This is a more difficult operative procedure than interruption of the superficial femoral vein and should be used only by the experienced surgeon when thrombosis involves the two veins. The inset shows the completely ligated and divided vein and in addition two of its tributaries to give sufficient length of vein to permit safe interruption with division.

vein and to remove existing thrombi from above as well as from below. A carefully used glass tubing suction tip aids in the removal of clots. Free bleeding from both ends of the vein is desirable. With strong suction after the thrombi are removed, one must guard against the removal of unnecessary blood. Our attention has been called to the reduction of the blood volume to shock levels by this method in an exceedingly short time.

The importance of interrupting the superficial vein at the highest possible level is emphasized by our only fatal case of embolus following prophylactic interruption. The superficial femoral vein had been divided 3 cm. below the vena profunda femoris, and at autopsy this segment of vein was thrombosed. This could easily have acted as a nidus for the propagation of thrombus of sufficient extent to occlude the pulmonary arteries when the whole mass became detached eight days later. This patient was fat and had a large ventral hernia to be repaired. The prophylactic venous interruption was justified on the basis of age, obesity and the character of the operation needed. There was no evidence that phlebothrombosis existed at the time of interruption of the femoral veins, and it must be assumed that such a condition occurred afterward. It has been pointed out

by Homans [8] and others that veins should be divided with a minimal segment below a free current of blood. Unless one isolates the vena profunda femoris sufficiently to determine the level of bifurcation of the common femoral vein there is danger of leaving too long a proximal stump of the superficial femoral vessel.

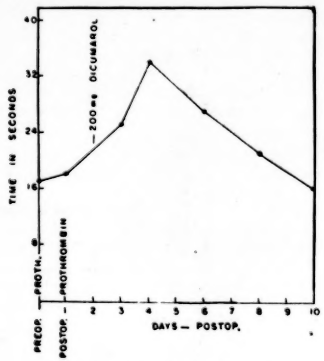

Fig. 3.—Typical response to one dose of Dicumarol.

Up to the time of this report there have been 1,281 patients subjected to interruption of the femoral veins for the prevention and treatment of thrombosis and embolism in the Massachusetts General Hospital

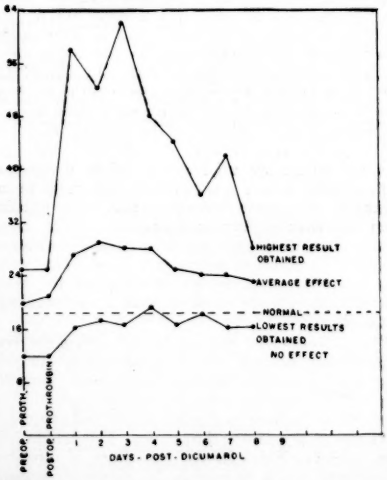

Fig. 4.—Composite curve of response of 165 patients to Dicumarol, measured by the Quick method, undiluted.

(table 3). No patient has died and no patient has lost an extremity as a result of these procedures. The majority of the house cases have been operated on by the resident surgeons. This has caused us to minimize the operative procedure too much and has led men to undertake the operation who had not studied the problem. Confusion has occurred regarding the exposure of the desired segment of the vein, and serious complications have resulted. It has come to our attention that these unnecessary sequelae are obviously the result of carelessness. The unexpected tearing of a vessel with the resultant bleeding requires the calm and calculating orientation that comes with experience. Incredible as it may seem, we are aware of ligation of the femoral artery, which had been mistaken for the vein, in 1 instance.

DICUMAROL

We have been interested in the use of all accredited methods of treating thrombosis and embolism. The anticoagulant drugs appeared at first likely to solve the

Table 3.—*Interruptions of the Femoral Vein, 1937 to June 1946*

	No. of Patients	Indications: Leg Signs as First Symptom, %	Indications: Pain in the Chest as First Symptom, %	Indications: Prophylactic Interruption, %
1937 to 1942	202	59.0	41.0	0
1943	165	56.3	34.5	9.2
1944	280	41.8	32.5	25.7
1945	392	31.7	23.0	45.3
1946 (June 1)	242	37.6	24.3	38.1
Total	1,281			

Table 4.—*Incidence of Interruption of the Femoral Vein, Jan. 1, 1945 to June 1, 1946*

	Age Groups I 1 to 39	II 40 to 64	III Over 65	Total
East Service (Dicumarol)				
Postoperative phlebitis	8	8	3*	19
Prophylactic	0	5	110	115
Admissions	789	965	321	
West Service (control)				
Postoperative phlebitis	9	35	14	58
Prophylactic	0	5	4	9
Admissions	812	963	310	

* Phlebitis developed which required interruption of the femoral vein before prophylactic interruption had been performed.

problem. Our experience with heparin not being as satisfactory as that of Murray and Best,[9] we were well on our way with use of interruption of the femoral veins when Dicumarol became available. We watched the reports on the use of this drug with much interest and made some sporadic observations of our own. Finally we determined to carry out the controlled clinical experiments that are reported here. It seemed obvious that this drug could not be used indiscriminately on all types of patients and that complete laboratory check on the serum prothrombin level was necessary. It also became evident that the response to this drug was variable (fig. 3). Strong robust persons could tolerate more of it than the older and weaker patients. Since we have two surgical services of identical size, both of which handle the same types of patients, we were able to use one service as a control until the value of Dicumarol could be established in our clinic. We

8. Homans, J.: Thrombosis of the Deep Veins of the Lower Leg, Causing Pulmonary Embolism, New England J. Med. **211**: 993-997 (Nov. 29) 1934.

9. Murray, G. D. W., and Best, C. H.: Use of Heparin in Thrombosis, Ann. Surg. **108**: 163-177 (Aug.) 1938.

selected the age group 40 to 65 for this test and used small doses (200 mg.) of the drug as soon after operative intervention as the patient could take it, i. e., within twenty-four to seventy-two hours. Prothrombin determinations were made preoperatively on both services on patients in this age group. It was found that a small percentage of patients without known hemorrhagic tendencies had an elevated prothrombin time and that about the same number had a lower than normal level (table 4).

From Jan. 1, 1945 to June 1, 1946, 162 patients on the East surgical service received one or more 200 mg. doses of Dicumarol. About two thirds of these patients acquired an appreciable elevation of prothrombin time after one dose of the drug (figs. 4 and 5). About one half of the remaining number reached a satisfactory level after a second dose. Doubtless some of these could have been given larger doses with benefit. However, we have lowered the incidence of thrombosis and embolism to about 25 per cent of that seen in the control group (table 5). In no case did severe hemorrhage occur that could not have been accounted for otherwise. There was occasional evidence of ecchymosis at the site of needle punctures and some bleeding into the tissues near the operative wound, but such manifestations are often seen in patients not receiving Dicumarol. One patient bled from an intestinal anastomosis; this has occurred in other similar operations.

TABLE 5.—*Comparative Data*

Incidence of postoperative phlebitis in the age group 40 to 64 on the East surgical service (Dicumarol treated) and the West surgical service (control), Jan. 1, 1945 to June 1, 1946.

East Service (Dicumarol)	8 cases
West Service (control)	35 cases

In 1 instance of sudden death, thought to be due to embolus ten days after gastric resection, no explanation of death was found at autopsy. Permission for examination of the brain of this patient was refused by the family, and the possibility of cerebral hemorrhage could not be ruled out.

Some persons are decidedly resistant to the drug, while the prothrombin of others will rise from a normal of 18 seconds to 65 seconds on one 200 mg. dose. Figure 6 shows the curve of a resistant patient. This patient had had interruption of the superficial femoral vein and because of further infarcts had had ligatures placed around the common femoral veins. He continued to have infarcts, and Dicumarol was administered. In spite of the fact that no measurable rise in prothrombin time took place until after the third 200 mg. dose had been administered, he had no further infarcts after forty-eight hours had elapsed subsequent to the first dose.

Some of the inquiries which we receive indicate that we have failed to make clear what we mean by "prophylactic" interruption of the femoral vein. After we have evidence that thrombosis of the veins of the legs has occurred, we have looked on phlebotomy, thrombectomy and interruption of the femoral vein more as a method of treatment. In fact, this is done with the idea of preventing further and more massive emboli and is therefore somewhat prophylactic. In our use of this term, however, we have meant to imply that the veins were interrupted prior to any evidence of thrombosis or infarct in order to prevent the occurrence of these complications. As seen in table 4, we are performing the interruption of the superficial femoral veins before, at the time of or shortly after the chief operative procedure in the older age group of patients. These normal veins are interrupted before thrombosis exists, and in no case save 1 instance (reported previously herein) has there been any evidence of thrombophlebitis or embolism in this entire group.

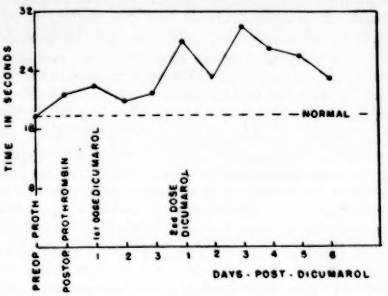

Fig. 5.—Response of 17 patients receiving two doses of Dicumarol, measured by the Quick method, undiluted.

When one considers that the patients selected for this prophylactic measure are—because of age, injury or disease—those most likely to have such a complication develop, it seems clear that greater use of this procedure should be made. Most of our early prophylactic interruptions were performed on the fracture service in patients with fractures near the hip joint. The high incidence of fatal embolus, particularly in intertrochanteric fractures, in our hospital made this procedure a welcome one to adopt. No fatal embolus has occurred in this group of patients since the prophylactic interruption of the superficial femoral veins has been the routine procedure. The urologic serice under the direction of Dr. Fletcher H. Colby and the gynecologic service under Dr. Joe V. Meigs have come to the conclusion that this procedure has much to commend it in preventing the development of thrombosis and embolism in elderly patients.

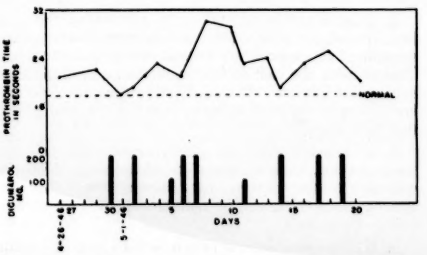

Fig. 6.—Response of Dicumarol-resistant patient, aged 29. Initial infarct, Feb. 24, 1946; bilateral interruption of the superficial femoral veins, February 22; infarct, March 24; bilateral interruption of the common femoral veins, March 25, and infarct, April 22, 1946.

It is difficult to convince the uninitiated that interruption of the normal superficial vein can be harmless. These patients not only have no complaints concerning

their legs, but only the slightest amount of transient swelling is observed in the feet and ankles. That they are protected from thrombophlebitis by this method in nearly all instances, we are certain. We have indisputable evidence of the almost certain elimination of serious infarct. After such a procedure the chief complication now seen in modern surgical practice is avoided. It is quite probable that this method of prevention of thrombosis and embolism will be extended into the middle-aged group in many cases and occasionally will be employed in the younger patients whose injury or disease makes such a complication likely.

In this entire group of 1,300 patients there have been only 6 deaths in which subsequent emboli, as proved at autopsy, played a role. One of these interruptions was performed as a prophylactic measure and has been previously discussed. It is of great interest that in all 5 remaining cases interruption of the veins was done because of one or more previous pulmonary infarctions. Two of these procedures were performed at the level of the common femoral veins, and in 3 instances the superficial veins were divided. All these patients, save 1, were in the seventh or eighth decades and were generally debilitated. In each instance the previous infarcts had so reduced the pulmonary vital capacity that subsequent emboli of smaller size resulted in death. Had any of these patients had an initial prophylactic interruption of the femoral veins, as indicated, it is probable that even fewer deaths would have occurred.

SUMMARY AND CONCLUSIONS

1. Interruption of the normal superficial femoral veins at the highest level possible will protect the patient from thrombosis and embolism. This is a harmless procedure, when properly carried out, and should be done within seventy-two hours of the onset of rest in bed or surgical intervention. It is particularly indicated in aged and debilitated patients.

2. Dicumarol given in small doses postoperatively will reduce the incidence of thrombosis and embolism to at least 25 per cent of that seen in controls. It is imperative to have regular laboratory determinations on the plasma prothrombin time before and during the administration of the drug. In patients with hemorrhagic tendencies, of any age, and in arteriosclerotic persons it should not be used.

3. Phlebothrombosis and early thrombophlebitis is best treated by phlebotomy, thrombectomy and interruption of the superficial femoral veins on both sides. This reduces the risk of fatal embolism and diminishes subsequent infarcts. It also shortens the convalescence and reduces the inflammatory reaction in and about the deep veins.

4. If infarcts continue after interruption of the femoral veins, anticoagulants should be used. Heparin will elevate the clotting time immediately, and this anticoagulant effect can be maintained with the slower acting Dicumarol.

5. If thrombophlebitis progresses to produce pain and swelling after interruption of the femoral veins, procaine block of the lumbar sympathetic nerves will relieve pain and hasten recovery.

6. Interruption of the inferior vena cava should be performed only for repeated septic infarcts that by signs and symptoms indicate their source to be from the pelvic or iliac veins.

ABSTRACT OF DISCUSSION

ON PAPERS OF DRS. AYCOCK AND HENDRICK, LOEWE AND HIRSCH, AND ALLEN, LINTON AND DONALDSON

DR. ROSS VEAL, Washington, D. C.: Differential diagnosis is most important, for proper treatment depends on correct diagnosis. All of us should recognize acute thrombophlebitis, particularly the femoroiliac thrombophlebitis. Phlebothrombosis presents a much more serious problem. In the early stage there may be no symptoms. Later these cases may simulate thrombophlebitis in local and general signs and symptoms. Regardless of the stage, until complete organization there is always present the potential danger of pulmonary embolism. In my experience in 1 of every 4 patients, if the appropriate vein is not ligated, pulmonary embolism develops. With regard to the use of venograms as an aid in the diagnosis of venous thrombosis of the lower extremities, it was believed several years ago that this was going to be an important aid in determining the course of therapy. This led to a false sense of security in regard to some patients, because the venograms did not demonstrate the presence of a clot in their veins. These patients were allowed to go untreated and fatal pulmonary emboli occurred. I have therefore discarded the use of venograms as a measure of how these patients should be treated. As to the point of ligation, my associates and I differ somewhat from the Boston group. We have always felt that we should ligate a major vein through a normal segment of that vein above the clot. If ligation is performed through a diseased portion of the vein, too frequently thrombosis develops above the point of ligation. Our rule now is to ligate through a normal segment of the vein, above the diseased portion or clot and just distal to a main tributary. This means that ligation may be performed through the femoral vein just below the saphenous in some and through the common iliac vessels in others; in still others it becomes necessary to ligate the vena cava. We have used local anesthesia in many patients, but we now favor the use of pentothal sodium and oxygen. We have often found that after pulmonary infarcts these patients are decidedly apprehensive and sometimes difficult to handle under local anesthesia. We believe that under an expert anesthetist anesthesia by means of pentothal and oxygen works well and is safe in such patients. In ligation of the major veins there is a danger which has not been stressed, and that is a sudden congestion of the limb below the level of ligation. We have had 4 instances in which, immediately after ligating a major vein, the leg became enormously swollen and the veins tremendously dilated, with petechial hemorrhages occurring throughout the tissues. Fortunately we recognized this quickly and by elevation of the leg to an extreme level and prompt blocks of the sympathetic nerves the circulation was quickly corrected. All 4 patients recovered without any loss of tissue and without any evidence that the congestion had caused permanent damage. I do not consider that after ligation of the major veins the extremity is perfectly normal. One must anticipate some swelling in the majority of these cases, depending on how extensive the thrombosis was at the time of ligation. If the clot has extended all the way up to the femoral triangle most of these patients are going to have some postoperative edema, but if that edema is controlled from the onset many will recover completely. However, if swelling of the leg continues, we may expect trouble with the skin, such as eczema and ulcers. Therefore, all our patients leave the hospital with a properly fitted elastic stocking, which they wear until there is no longer any swelling.

DR. ALTON OCHSNER, New Orleans: Whereas in Boston they ligate everything, in New York they ligate nothing. We take the rational middle ground and ligate those that should be ligated and don't ligate those that need not be ligated. Dr de Bakey and I believe that there is a definite difference between the two types of venous thrombosis—phlebothrombosis and thrombophlebitis—and although the patient with phlebothrombosis who is fortunate enough not to die as a result of a detachment of his thrombus will ultimately develop an inflammatory process so that the thrombus becomes attached, that is not the way most cases of thrombophlebitis begin. On the other hand, we are convinced that thrombophlebitis usually begins as a primary inflammatory lesion in the vein. The

cause may be bacterial, it may be toxic or it may be allergic, but the process fundamentally is different from that in phlebothrombosis. Dr. Hendrick has emphasized the importance of prophylaxis; this is extremely important. Not only can pulmonary embolism be prevented by preventing the detachment of the clot when it is once formed, but one can usually prevent the formation of the thrombus. Dr. Hendrick mentioned the value of certain postures and the danger of other postures. We go farther than that. We feel that any patient past 40 years of age—and we would agree with Dr. Allen that age is a factor—who has trauma from any cause, operative or otherwise, should have his lower extremities compressed from his toes to his groin and should be made to contract his muscles actively, and particularly his calf muscles, against a resistance. I thoroughly agree with Dr. Linton that ambulation means ambulation, and the worst thing that one can do is let a patient get out of bed and sit. It is far better that the patient remain in bed in a horizonal position and actively and forcibly bend or flex his foot against a resistance. There will be a few cases of phlebothrombosis which will develop even under this therapy. It is a rule on our service that twice daily the calves of patients are compressed, and forceful dorsal flexion of the foot is carried out, as suggested by Dr. Homans. In this way we can detect phlebothrombosis in its incipiency and, as Dr. Linton has suggested, we think that these cases require ligation. I have seen too many patients in consultation in whom anticoagulants have been used with the idea that the patient was perfectly safe, and yet they have had repeated emboli. I am sure that anticoagulants will prevent the formation of new thrombi, but I am also sure that they will not guarantee against the detachment of the thrombus already there. I have no objection to anticoagulants; I think it is well to use them. The use of anticoagulants is primarily prophylactic, as Dr. Linton says, but it is dangerous to use and to rely on such drugs alone, because the clot that is already there and not detached can still become detached, even though one does prevent the formation of other thrombi.

DR. FREDERICK W. BANCROFT, New York: I wish to protest against Dr. Ochsner's statement that we never ligate veins in New York. It has been my good fortune to work with Dr. Loewe in several cases and to have used his menstruum in at least 10 patients, independently. There is no doubt that the heparin-Pitkin menstruum provides the anticoagulant effect and is infinitely superior to the continuous intravenous administration of heparin. I agree with Dr. Loewe that venostasis is a decidedly important factor in thromboembolic diseases. As an example, I might mention 4 cases of phlebothrombosis of the femoral vein occurring during rest in bed, after an attack of coronary occlusion. After the removal of the clot from the iliac vein it was possible to mobilize these patients immediately, whereas the use of anticoagulants would have kept them in bed for a longer period. While I agree with Dr. Loewe that a majority of cases of phlebothrombosis originate in the deep veins of the calf, there is another type starting from the uterine veins, and pulmonary infarcts have resulted before there is evidence of retrograde thrombosis of the thighs or legs. There are three types of cases in which we would hesitate to use anticoagulants; first, immediately after pregnancy; second, in phlebothrombosis following hemiplegia from hemorrhage, and third, in phlebothrombosis following coronary occlusion. I disagree with Allen and his co-workers that it is necessary to ligate both sides every time. In my experience if the thrombus starts from the veins in the calf and is seen early and that vein is ligated, I have never seen it occur on the other side. On the other hand, when it has started in the pelvis, I have had experience to indicate that the veins on both sides should be ligated simultaneously. Dr. Loewe has made a great contribution in his heparin-Pitkin menstruum, in making the administration of heparin much simpler, safer and less expensive.

DR. GEZA DE TAKATS, Chicago: In a group of 251 patients on our service, we have seen 1 fatal and 2 nonfatal pulmonary emboli, so that our treatment has justified itself at least in a small series of cases. At least 40 per cent of these patients are admitted or are seen with thoracic symptoms before any localizing symptoms occur in the periphery. With the combination of oxygen, atropine and papaverine, and also heparin, a number of lives can be saved. It is difficult to put this on a statistical basis, because a number of patients with pulmonary emboli recover, but the response to this treatment is often dramatic. Symptoms of a pulmonary embolus are due to a sudden obstruction of the pulmonary arterial tree plus an intense vasospasm of the unaffected part of the pulmonary artery, a bronchial spasm and a sudden coronary insufficiency. When the origin of the embolus is recognizable we ligate above the level of the recognized thrombus. This might be the superficial femoral, the common iliac or the vena cava. When the origin of the embolus is unknown, we do not use any phlebograms but institute anticoagulant therapy, by which we mean heparin, for two days in intermittent doses—50 mg. every four hours intravenously—and Dicumarol. It is important that Dicumarol be given in adequate amounts, so that the isothrombin level is at least 50 per cent below normal. If one does not do that, one is not really protecting the patient. One or two doses of 200 mg. of Dicumarol are nonprotective. We have discharged a number of patients on small amounts of Dicumarol; those, for instance, who have had arterial emboli following coronary occlusion. Such patients take 200 or 300 mg. of Dicumarol every week, and the incidence of emboli in this group has been just as high as in the ones who have not received it; this drug must be given in therapeutically effective doses. When one suddenly stops the administration of heparin or of Dicumarol, there may be a thrombosis. We have observed such an occurrence in 3 instances. If treatment with heparin or Dicumarol is to be discontinued, it must be stopped slowly, and it must not be continued in the ambulant patient. There is no reason why the surgeon should not use anticoagulants in conjunction with surgical therapy, just as a surgeon will amputate a diabetic toe and still use insulin. Dr. Loewe's subcutaneous heparin is the most promising new development, and perhaps improvements can be made to make the solution less painful and irritating so that the general medical practitioner can use it. At present the combination of surgical treatment with anticoagulant therapy gives the smallest incidence of fatal pulmonary emboli.

DR. KURT LANGE, New York: After we had found that heparinization was able to prevent the gangrene subsequent to frostbite, Dr. Loewe was kind enough to let us try some of our frostbite lesions on his patients who were to be heparinized anyway for endocarditis, and although the heparinization in these patients with the heparin-Pitkin menstruum succeeded excellently in keeping the clotting time at the desired level, to between 30 and 60 minutes, it was rather conspicuous that the patients had great pain at the site of the injections. We do not put too much attention on that, for the advantage of an intramuscular heparin is such a great one, especially in the treatment of thromboembolic disease, that we think it would not matter whether or not it was painful. We were especially enthusiastic, for we thought that in our animal experimentation we would now be able to give heparin once a day and then forget about the animal for twenty-four hours. When we did that we found that of 160 animals thus treated (120 rats and 40 rabbits) 150 died at the third or subsequent day, with the clotting time between 30 and 60 minutes at the time of their death. At autopsy it was found that all of them had died from anemia, sanguinating into the site of the injection, where tremendous hematomas were found. That means that apparently the small capillary bleeding which was caused by the injection could not stop when large deposits of heparin were underlying this bleeding. I would like to ask Dr. Loewe whether in his cases in which autopsies were performed these sites of injection were examined or whether aspirations were done at the sites of injection to find out if the pain is not the result of a subcutaneous hematoma which, in the human being, does not become as great in extent on account of the local circumstance of the tissue.

DR. RALPH ADAMS, Boston: I wish to mention another group treated in Boston. In something over 9,000 operations performed during the last four years, we have recognized thromboembolic phenomena in 170 patients treated with heparin and Dicumarol and in 8 by ligation. We lost 1 patient who had been adequately treated with the anticoagulants; we lost

133
947

1 patient, after bilateral ligation of the vein, who had one single dose of Dicumarol and a second patient who was Dicumarol-resistant. In this same period we had 40 deaths from pulmonary embolism in patients who had no recognized sign of thrombosis or embolism preceding the fatality. The question is, should we have performed ligations to prevent this tragedy in all patients over the age of 40, who in our group represent nearly 50 per cent of those having major operative procedures? That would amount to approximately 4,500 ligations. The second question is, if we are to use anticoagulation prophylactically, when should it be started postoperatively? Since we have started the energetic use of foot exercises, with preoperative instructions in writing in all languages necessary to be read by our heterogeneous group of patients the incidence of thromboembolic phenomena has been reduced by about 50 per cent.

DR. JAMES W. HENDRICK, Baltimore: There are so many important phases of this subject, it is difficult to cover them all in the time allotted. Since the University of Maryland hospital is a state institution, a large number of patients in the older age group are admitted. Consequently, an appreciable number are candidates for venous thrombosis, unless caution is exercised to prevent this complication. We consider, as Dr. Ochsner has stressed, that prevention is the main factor. Members of our resident and nursing staff are taught to carefully note any indication of this complication. Also each patient is given instructions to help prevent it, as was mentioned by Dr. Adams of the Lahey Clinic. Relative to Dicumarol therapy, we have found it to be contraindicated in prostatic and thyroid surgery, and in disease of the liver. We think it should be used with caution and only given when careful determinations of prothrombin time can be made every twenty-four hours. We have seen several patients that were sent in from the surrounding territory in whom massive hemorrhages had developed following Dicumarol therapy after a surgical procedure. Such patients required large doses of vitamin K to prevent death. We would like to stress again that a careful differential diagnosis should be made between phlebothrombosis and thrombophlebitis. If phlebothrombosis is present paravertebral blocks should not be done. But thrombophlebitis will respond to paraverterbral blocks. This procedure was first reported by Dr. Ochsner and his group. We inject the first, second, third and fourth lumbar ganglions with 10 cc. each of a 1 per cent solution of procaine hydrochloride. We also inject the second and third ganglions each with 10 cc. of monobromosaligenin (Bromsalizol) solution. The latter solution was developed by Dr. Ferdinand Lee and his co-workers at the Baltimore City Hospital and the Johns Hopkins Hospital. The procaine solution acts instantly but begins to lose its effect after twelve hours to twenty-four hours; monobromosaligenin is slower, but the effect will last from four to eight days. This procedure is not difficult to execute and can be used by physicians over the entire country, who have been properly trained in the technic of administration.

DR. ROBERT R. LINTON, Boston: In answer to Dr. Adams' question, what are we going to do with 4,500 patients over 40 years of age who undergo major surgical operations at our clinic? I did not mean to infer that every patient over 40 years of age should have his femoral veins interrupted. I meant to stress the importance of prophylactic interruption of the femoral veins in patients over 50 years of age who are operated on for abdominal cancer. It is possible after a little training to do bilateral interruptions of the superficial femoral veins in a short while. It usually takes not longer than twenty minutes. Until it has been proved that prophylactic interruption of the superficial femoral veins is not adequate protection against pulmonary embolism, I believe that it is well worth while spending anywhere from twenty minutes to half an hour to perform this simple procedure. To date we have carried out this procedure in some 358 patients. There was 1 death in this group of prophylactic interruptions. At autopsy it was seen that the interruption was about 3 cm. below the junction of the superficial and profunda femoris veins. This definitely was a technical error, as a thrombus was found in this blind segment of superficial femoral vein below the profunda branch. The junction of the superficial and the profunda femoris veins must be visualized, and if the superficial femoral vein is tied it must be done at the junction, so that there is no blind segment of vein distal to the point at which the superficial and profunda femoris unite to form the common femoral vein. Anticoagulants should be used mainly in the prophylaxis of venous thrombosis. They should be used also after the femoral veins have been interrupted if a secondary sublethal embolus develops. One of the chief arguments against interruption of the femoral veins is that one must surely damage the extremity by interrupting its main venous channel. At first we were fearful of this, but after well over 2,000 such interruptions without the development of any serious consequences in these patients, we feel assured that it is a safe procedure. We as well as others are now interrupting the femoral veins in the postphlebitic group of patients that present the chronic indurated ulcers that have been so hard to heal in the past. From a physiologic point of view it must be realized that these large venous channels in the lower extremity are not necessary as conduits for blood; they are mainly reservoirs of blood which can be interrupted without damaging the patient's health or his extremities.

DR. LEO LOEWE, Brooklyn: We have successfully treated with heparin Pitkin menstruum patients in whom bilateral ligation of the femoral veins failed to prevent recurrent pulmonary embolization. Dicumarol failures which were referred to us were then successfully treated with heparin/Pitkin menstruum. The disadvantages of Dicumarol have been pointedly demonstrated by Dr. Linton; the dosages are haphazard, and propagation of thrombus—even pulmonary embolization—can occur despite apparently adequate doses. In addition to being toxic and difficult to control the action of the drug is delayed. Its chief virtue is that it can be administered by mouth. The issue of venous ligation versus anticoagulant therapy requires more statistical proof before it can be resolved. We have had no instance of lethal pulmonary embolization since our optimum treatment program has been established. The painful local reaction mentioned by Drs. de Takats and Lange has also been observed with Pitkin menstruum preparations containing agents other than heparin. This objection has now been remedied by the use of more physiologically acceptable gels. There is the question of local hemorrhage raised by Dr. Lange. His experience has been limited to animal experiments. Those of us who have used the heparin/Pitkin menstruum, including Drs. Bancroft, Blakemore of the Columbia-Presbyterian group and Evans of the Lahey Clinic, have never encountered anything that has purported to be hemorrhage. In heparinizing over 200 rabbits and about 400 patients, totaling several thousand injections, we did not see the reactions described by Dr. Lange in his experiments with rats. The reason is obvious. If he would analyze his dosages he would find that in a definite attempt to raise the coagulation time to levels consistent with his experimental requirements he has given his rats 15 to 20 mg. of the drug daily. This is the equivalent by weight to a daily human dose of about 2,500 mg. as contrasted with the recommended human dose of 300 mg. every other day.

Pulmonary Air Embolism.—Basic to an understanding of pulmonary (venous) air embolism is a clear conception of its differentiation from the arterial form of air embolism. Although both depend for their effects on the presence of air in the circulation, the site of entrance of the air determines its distribution within the vascular system and is therefore extremely important. In the pulmonary form, air enters one of the systemic veins and is carried to the right heart and pulmonary circulation and depends for its effects on mechanical obstruction of the outflow tract of the right ventricle. Fairly large amounts of air are needed to produce this effect. In arterial embolism the air gains entrance to the pulmonary venous channels and is propelled from the left ventricle to those systemic arteries which supply the superiorly located portions of the body. Since a small amount of air can effectively block a medium sized artery, serious consequences may result when a few cubic centimeters of air enter the pulmonary vein and are carried into either the coronary, or cerebral, circulation, or both. . . . As would be expected, the clinical picture in the two forms of embolism is totally different.—Durant, Thomas M.; Long, Joan, and Oppenheimer, Morton J.: Pulmonary (Venous) Air Embolism, *Am. Heart J.*, March 1947.

THE TREATMENT OF SERUM SICKNESS WITH BENADRYL

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and
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The recent report of State and Wangensteen [1] was the first concerning the use of a drug having a satisfactorily specific therapeutic action in the treatment of serum sickness. They successfully employed intravenous injections of procaine hydrochloride to abolish the manifestations of serum sickness. In the past two years we have had an opportunity to observe the effect of Benadryl hydrochloride, a drug related to procaine, in the treatment of 10 patients with serum sickness. These patients responded to the oral administration of the drug.

STUDY MATERIAL

Serum sickness developed in our patients as a complication of serotherapy for a variety of conditions; 4 infants and 1 child from treatment with meningococcus antitoxin, a fairly crude horse serum preparation; 1 child from treatment with polyvalent antivenin, also a relatively crude horse serum preparation; 1 infant from treatment with diphtheria antitoxin, a more highly refined horse serum preparation, and 2 infants and 1 child from treatment with type B anti-Hemophilus-influenzae serum, a highly refined rabbit serum preparation. Brief reports of the individual cases follow.

REPORT OF CASES

CASE 1.—W. N., a white boy aged 2 months, received 10,000 units of meningococcus antitoxin intramuscularly on March 7, 1945, for meningococcic meningitis. The preliminary intradermal sensitivity test was negative. Ten days later there developed a generalized urticarial eruption. Treatment with Benadryl hydrochloride, 50 mg. orally every twelve hours, was instituted. There was no response during the succeeding forty-eight hours. The dosage was increased to 50 mg. of the drug every six hours, and the rash disappeared completely after the second dose. The therapy was discontinued after another twenty-four hours. There was no recurrence of the rash. The rash was this patient's sole manifestation of serum sickness.

CASE 2.—C. S., a white boy aged 3 months, received, by intramuscular injection, 20,000 units of meningococcus antitoxin on May 14, 1945, in the treatment of meningococcic meningitis. He had shown a negative intradermal sensitivity test. Five days later a generalized urticarial eruption appeared. Benadryl therapy, 50 mg. orally every eight hours, was instituted on May 19, and the rash completely disappeared following the second dose. Therapy was discontinued on May 21, and the rash reappeared on May 22. It again disappeared after the second 50 mg. dose with an eight hour interval. Therapy was continued until May 27. There was no subsequent recurrence of symptoms. Elevation of the temperature to 99.8 F. was the only other manifestation of serum sickness in this case. The response to therapy is shown in figure 1.

CASE 3.—P. P., a white girl aged 2 years, who had meningococcic meningitis, contracted an urticarial eruption on Feb. 11, 1945, eight days after the administration of 20,000 units of meningococcus antitoxin. The intradermal sensitivity test had been negative. Treatment with Benadryl, 50 mg. every twelve hours, failed to relieve the symptoms, but on May 14 an increase of the dosage to 50 mg. of the drug every eight hours resulted in complete disappearance of the rash. It was thought that the serum sickness which was mild might have terminated. The therapy was stopped, and in fourteen hours there was a recurrence of the rash. Treatment with 50 mg. of Benadryl every eight hours relieved all symptoms. Treatment was discontinued without recurrence on May 16. This patient showed only an elevation of temperature to 100 F. in addition to the urticarial rash.

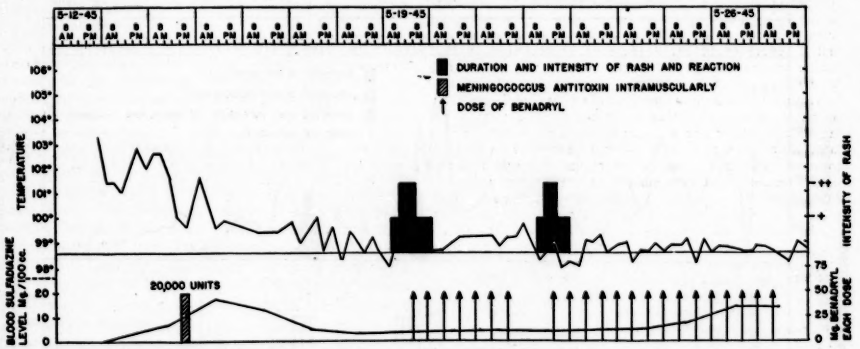

Fig. 1 (case 2).—Serum sickness following meningococcus antitoxin and its response to therapy with Benadryl hydrochloride.

CASE 4.—S. H., A white boy aged 8 years, received 15 cc. of antivenin on Aug. 1, 1945, for a copperhead (Agkistrodon mokasen) snake-bite. An intradermal test with the antivenin had been negative. A generalized macular erythematous eruption developed nine days later, and the boy was obviously ill and irritable, but no other symptoms of serum sickness were observed. Treatment with Benadryl, 50 mg. orally every four hours, caused the disappearance of the rash after the second dose. He was also generally improved. The Benadryl dosage was reduced to 50 mg. every eight hours and was discontinued after three such doses. Fourteen hours later the rash reappeared. Therapy with 50 mg. of Benadryl every eight hours was reinstituted, and there was no recurrence when it was discontinued on August 27.

CASE 5.—B. M., a white boy aged 4½ years, with meningitis due to type B H. influenzae had a diffuse macular erythematous eruption which developed ten days after the initial intramuscular injection of type specific rabbit antiserum on Dec. 3, 1945. He received 125 mg. of agglutinin antibody nitrogen equivalent on the first day and an additional 25 mg. on the second and fourth

From the Department of Pediatrics, Vanderbilt University School of Medicine.

Benadryl, beta-dimethyl aminoethyl benzohydryl ether hydrochloride, was supplied by Parke Davis & Company.

1. State, D., and Wangensteen, O. H.: Delayed Serum Sickness, J. A. M. A. **130**: 990 (April 13) 1946.

days. Shortly after the rash appeared he was given Benadryl, 50 mg. orally. The rash faded promptly but recurred after sixteen hours. Treatment with 50 mg. of the drug every eight hours resulted in disappearance of the rash after the second dose. At the end of the third day after the onset of serum sickness administration of the drug was discontinued without recurrence of the rash. There were no other manifestations of serum sickness in this case.

CASE 6.—R. S., a boy aged 2 years with meningitis due to type B H. influenzae was given specific rabbit antiserum containing 100 mg. agglutinin antibody nitrogen equivalent intramuscularly on Jan. 6, 1946. The intradermal sensitivity test with a 1:10 dilution of serum was 2 plus positive. Serum containing 25 and 50 mg. agglutinin antibody nitrogen equivalent was administered on the second and third days, respectively. On January 16 there developed a macular erythematous eruption and urticaria. The child also vomited but did not show other manifestations of serum sickness. He was given 50 mg. of Benadryl initially, followed in four hours by 40 mg. of the drug. There was little improvement in the rash so the dosage was increased to 50 mg. every four hours, with some, but incomplete, improvement. After three such doses a further increase to 60 mg. of the drug every four hours resulted in pronounced improvement; the urticarial component disappeared, but there was some rash throughout the forty-eight hours of therapy at this level. However, the patient was much less irritable and the vomiting associated with the rash ceased.

CASE 9.—J. M., a white girl aged 3½ months with meningitis due to the Diplococcus mucosus was given 10,000 units of meningococcus antitoxin on Feb. 2, 1946, after a negative conjunctival test with a 1:10 dilution of the antitoxin. Four days later there developed a rather fine diffuse macular and urticarial eruption; she began to vomit and her temperature rose from 99 to 102.8 F. Because of the seriousness of her reaction she was given a large initial dose of Benadryl, 100 mg., which was followed in four hours by a 50 mg. dose. The rash cleared completely in about one hour after the second dose. The fever and vomiting ceased twelve hours after the initial dose of Benadryl. Benadryl therapy was discontinued after five doses, and in twelve hours the rash reappeared. Benadryl therapy was reinstituted, the patient receiving 75 mg. initially followed by 50 mg. every four hours for an additional two days. There was complete relief with no recurrence after the discontinuance of treatment.

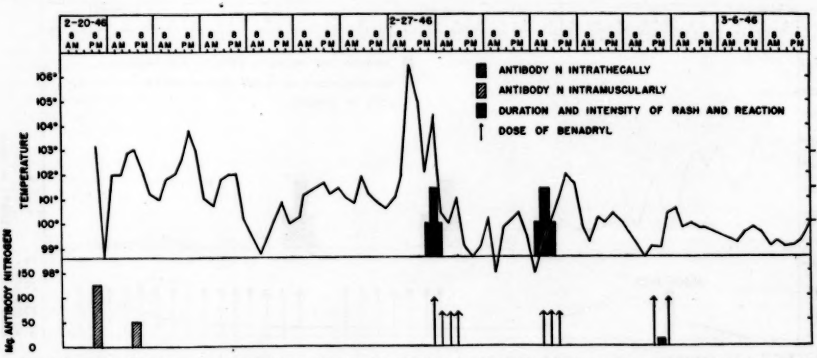

Fig. 2 (case 10).—The response of serum sickness following the administration of anti-H. influenzae serum type B (175 mg. of agglutinin antibody nitrogen equivalent) to treatment with Benadryl hydrochloride.

CASE 7.—F. T., a white boy aged 20 months, was admitted to the hospital on Jan. 11, 1946 with acute laryngeo-tracheobronchitis. He had received injections of 10,000 units of diphtheria antitoxin on each of three successive days prior to hospitalization. On January 16, eight days after the first injection of antitoxin, a generalized erythematous macular eruption developed. Treatment with 50 mg. of Benadryl every four hours was started. In two hours after the initial dose the rash had completely disappeared. No recurrence was noted when therapy was discontinued on January 18. This was an extremely mild case with no symptoms except the rash.

CASE 8.—R. L., a white girl aged 4 months with meningococcic meningitis, was given 10,000 units of meningococcus antitoxin intramuscularly on Jan. 30, 1946. The conjunctival sensitivity test with a 1:10 dilution of the antitoxin had been negative. Because of the extremely poor condition of the patient an additional 10,000 units of antitoxin was given about ten hours after the initial dose. On February 4, five days after the initial administration of antitoxin, there developed a mild urticarial eruption on the abdomen of the patient. The next day the rash was generalized and was confluent over the trunk. The infant also vomited several times, but there was no fever or lymphadenopathy. Treatment with elixir of Benadryl, 30 mg. every four hours, was instituted, and only a few lesions remained one hour after the second dose had been given. The patient, however, frequently vomited the elixir and on February 6, after she had lost two doses in this manner, the rash recurred. Though the dose of elixir was increased to 60 mg. every four hours the continued vomiting was enough to void the treatment, and the rash persisted. Benadryl powder, 100 mg., was substituted for the elixir on February 8. The rash faded completely within four hours. Maintenance therapy with 50 mg. of Benadryl every four hours was continued. No recurrence of symptoms was noted subsequent to cessation of therapy on February 10.

CASE 10.—C. E., a girl aged 9 months with meningitis due to type B. H. influenzae received an intramuscular injection of type specific rabbit antiserum containing 125 mg. agglutinin antibody nitrogen equivalent on Feb. 20, 1946. The preliminary intradermal sensitivity test had been negative. On the following day an additional 50 mg. was given because she had an inadequate serum antibody titer. Seven days after the initial serum injection there developed a macular erythematous urticarial eruption over the entire body of the patient. She had shown progressive improvement to this point, though the infection had not been completely controlled. With the development of the serum reaction she became critically ill, showing Cheyne-Stokes respiration, temperature elevation to 106.4 F. and slight cyanosis. Treatment with Benadryl, 50 mg. for the initial dose and 37.5 mg. every four hours for four doses, resulted in disappearance of the rash and definite improvement in her general condition. At the end of twenty-four hours the administration of Benadryl was discontinued because of increasingly severe vomiting. The child also had as a further complication moderately severe alkalosis as a result of the sodium bicarbonate given in conjunction with her sulfadiazine therapy. Thirty-six hours later there again developed fever and a rash, but the patient responded rapidly to therapy with Benadryl, 3 doses of 37.5 mg. each given at four hour intervals. On March 4, forty-

eight hours after receiving the last dose of Benadryl, she was given 15 mg. of type specific rabbit serum intrathecally. A prophylactic dose of 50 mg. of Benadryl was given at 4 p. m., the serum was injected at about 5 p. m. and an additional dose of Benadryl was given at midnight. Her recovery from this point was uneventful. There was no evidence of immediate or delayed serum reaction after the intrathecal injection. This patient's response to Benadryl therapy is summarized in figure 2.

COMMENT

Serum sickness is a fairly frequent complication of heterologous serotherapy. While it occurs much more commonly after the use of crude serum or relatively crude preparations, such as the currently available meningococcus antitoxin, it also follows the use of highly refined antibody globulin preparations. This is shown by the occurrence of serum sickness in cases 5, 6 and 10 after the administration of highly refined anti-H. influenzae serum.

The occurrence of serum sickness constitutes a disagreeable and troublesome illness in otherwise healthy persons, but it is often a serious complication when it occurs during the course of meningitis, tetanus or diphtheria.

The histamine concept of serum sickness, first advanced by Dale and Laidlaw [2] in 1910, has gained wide acceptance. The studies of Loew and his associates [3] showing the comparative efficacy of beta-dimethylaminoethyl benzohydryl ether hydrochloride (Benadryl) in combating histamine aerosol-induced bronchiolar constriction in guinea pigs suggested that the drug would be useful in the treatment of a variety of allergic disturbances. Although a number of early reports have appeared showing its effectiveness in the treatment of urticaria, there has been little said specifically in regard to its effectiveness in serum sickness. Friedlaender and Feinberg [4] report the control of 3 cases of "serum sickness-like" reactions associated with penicillin therapy, and Todd [5] reported on the control of whealing reactions subsequent to skin tests with horse serum, but we have been unable to find any reports on the use of Benadryl hydrochloride in the treatment of true serum sickness.

The report of State and Wangensteen [1] and more recently that of Applebaum, Abraham and Sinton [6] concerning the use of intravenous procaine therapy for serum sickness attests the need of remedies more effective and certain than epinephrine, theophylline ethylenediamine and calcium gluconate.

Our studies have shown that the early, and presumably the later and severer, symptoms of serum sickness can be completely controlled by Benadryl. The mode of action of this drug has not been entirely explained. It has been shown that it abolishes the vasodilatation from histamine and that it serves generally as an antispasmodic agent. Repeated oral doses of Benadryl as high as 8 mg. per pound (0.5 Kg.) of body weight (in small infants) were tolerated without side reactions. Nausea did occur in several instances but was troublesome only once, in case 10. It occurred more frequently in the use of the elixir than in the use of the powder. We encountered no difficulties in the use of the powder even in small infants, into whose mouths the capsule was simply emptied, using care to prevent aspiration. There was no observable local effect on the mucous membranes, though such topical application serves to partially anesthetize the tongue and buccal surfaces.

The effective dose of Benadryl for the treatment of different allergic manifestations is still being studied. From our cases it is apparent that doses of 50 mg. of the drug may not always be adequate to control the rash of serum sickness even in an infant 4 months of age, as in case 6, or a child aged 2, as in case 7. It is probable that the drug is effective in proportion to its concentrations in the tissues and that it will require two or three times as much per pound (0.5 Kg.) of body weight to control symptoms in infants as compared with adults.

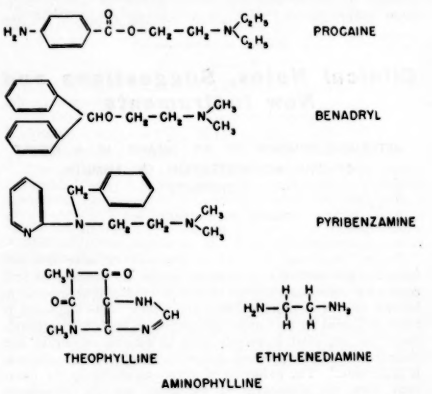

Fig. 3.—The chemical formulas of some of the drugs effective in the control of some histamin-like reactions.

The drug appears to have only suppressive action in serum sickness, as in urticaria, and it is necessary to continue the medication as long as the serum reaction would persist untreated. In mild cases this may be only a day or two, while in severe cases treatment for more than a week may be necessary. In our patients we withdrew the drug early, first, to convince ourselves, by allowing relapses, that the drug was truly effective and that we were not simply observing mild abortive reactions; and second, to ascertain how long the effect of an individual dose would last. The relapses which followed withdrawal in several instances confirm the real effect of the drug. The period of effect of the drug is not so clear but would seem from our cases to be somewhere between six and twelve hours, though the effect of extremely large doses might persist longer. We cannot say whether or not there is an appreciable cumulative effect when doses are given less frequently than every eight hours, but doses at four, six and eight hour intervals seem to have some cumulative effect. This was indicated by the fact that several times a second dose succeeded in eliminating symptoms

2. Dale, H. H., and Laidlaw, P. P.: The Physiological Action of B-Iminazolylethylamine, J. Physiol. **41**: 318, 1910.

3. (*a*) Loew, E. R.; Kaiser, M. E., and Moore, V.: Synthetic Benzhydryl Alkamine Ethers Effective in Preventing Fatal Experimental Asthma in Guinea Pigs Exposed to Atomized Histamine, J. Pharmacol. & Exper. Therap. **82**: 120 (Feb.) 1945. (*b*) Loew, E. R., and Kaiser, M. E.: Alleviation of Anaphylactic Shock in Guinea Pigs with Synthetic Benzhydryl Alkamine Ethers, Proc. Soc. Exper. Biol. & Med. **58**: 235 (March) 1945.

4. Friedlaender, S., and Feinberg, S. M.: Histamine Antagonists: III. The Effect of Oral and Local Use of B-Dimethylaminoethyl Benzhydryl Ether Hydrochloride on the Whealing Due to Histamine, Antigen-Antibody Reactions, and Other Whealing Mechanisms; Therapeutic Results in Allergic Manifestations, J. Allergy **17**: 129 (May) 1946.

5. Todd, L. C.: Some Clinical Observations on the Use of Benadryl for the Symptomatic Relief of Allergic Conditions, Ann. Allergy **4**: 282 (July-Aug.) 1946.

6. Appelbaum, E.; Abraham, A., and Sinton, W.: A Case of Serum Sickness Treated with Procaine Intravenously, J. A. M. A. **131**: 1274 (Aug. 17) 1946.

residual from the first dose. In every instance 100 mg. of the drug completely abolished all manifestations of the serum sickness within a period of two to three hours.

It is probable that future studies with the intravenous use of Benadryl will result in the development of improved technic for the control of the major crises in serotherapy.

It is interesting to note that the drugs recently investigated and found of value in the control of the histamine-like allergic reactions—theophylline ethylenediamine (aminophylline), Benadryl, procaine, pyribenzamine (N′pyridyl-N′benzyl-N-dimethylethylenediamine) and others—show certain structural similarities. All of them contain an aminoethyl or an ethylene diamine group [7] (fig. 3).

SUMMARY AND CONCLUSION

1. Ten cases of serum sickness have been treated successfully with Benadryl hydrochloride; 9 of the 10 cases were completely controlled, and the other was much improved.

2. Adequate therapy with this drug was found to consist of 50 to 100 mg. doses given at six to eight hour intervals and continued for the duration of the serum sickness.

Clinical Notes, Suggestions and New Instruments

METHEMOGLOBINEMIA IN AN INFANT AS A RESULT OF THE ADMINISTRATION OF BISMUTH SUBNITRATE

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Despite occasional reports [1] of fatalities or near fatalities from the administration of bismuth subnitrate the drug is still commonly prescribed in the treatment of diarrheal disease in infants as well as older children and adults. The statement is made in Useful Drugs [2] under the section on bismuth compounds that "the salt most frequently used is bismuth subnitrate, but since this sometimes produces poisonous effects, the subcarbonate is preferable." The reduction of nitrate to nitrite by the intestinal flora, the absorption of the latter and the subsequent development of methemoglobinemia is supposed to be a recognized danger but a seldom considered sequence. The following case report is considered worthy of note to emphasize the possibly lethal effects of bismuth subnitrate and to reemphasize the method of treatment which may often be an emergency life saving measure.

REPORT OF A CASE

An infant aged 5 weeks and weighing 8¼ pounds (3,856 Gm.) was admitted to the medical service of the Children's Hospital with a chief complaint of "blueness" of four hours' duration. The infant's birth and neonatal progress had been uneventful except for short periods of intermittent diarrhea which lasted two to three days. For this difficulty numerous changes of formula had been prescribed. At the time of admission he had been on a formula composed of "Dryco" and water. On the day prior to admission, because of twenty-four hours of fussiness and diarrhea, bismuth subnitrate powder had been prescribed in half-teaspoon doses to be placed in each bottle of formula. Three such feedings were given during the afternoon and evening of the day prior to admission. Eighteen hours after the initial dose the parents noted that the infant's face had become blue and that this hue had rapidly spread over the whole body. This progression was said to have occurred in only a few minutes. At the same time his breathing had become extremely rapid and labored. Physical examination on admission showed that the temperature was 101 F., the pulse rate 184 per minute and the respiratory rate 60. Respiration was deep and typical of air hunger. The skin presented a deep slate-colored cyanosis which involved the entire surface of the body. The heart was observed to be slightly enlarged, and a moderate apical systolic murmur was heard. The remainder of the examination was not noteworthy.

The baby was immediately placed in a Burgess-type oxygen tent with oxygen at high concentration. This procedure diminished the dyspnea but caused no appreciable change in the cyanosis. Blood which was drawn for examination was chocolate colored. The hemoglobin (Sahli) was 10.8 Gm. per hundred cubic centimeters, and the erythrocyte count was 3.3 million per cubic millimeter. On the supposition that fresh hemoglobin would aid the infant, 100 cc. of washed, resuspended red blood cells were infused through a vein of the scalp. This, however, resulted in a decided increase in the cyanosis. While attempts were being made to prepare and administer methylene blue by vein, 50 mg. of methylene blue in 120 cc. of 5 per cent dextrose were given by mouth. Within fifteen minutes the cyanosis had totally disappeared and the infant was breathing normally. No intravenous methylene blue was needed. The initial oral dose was repeated at four hour intervals for three doses, but return of the cyanosis was not observed. The infant was discharged after forty-eight hours and when seen again six days later was thriving. The heart murmur heard on admission had disappeared.

Prior to treatment, blood was drawn into an oxalated tube and stored under oil in the refrigerator. Analysis of this blood [3] after eighteen hours showed 48 per cent methemoglobin. In stored shed blood there is a spontaneous decrease in methemoglobin. The rate of decrease is conditioned by the amount of methemoglobin-forming substances remaining in the blood. In this instance the blood at the time of withdrawal must have contained somewhat more methemoglobin than the analysis revealed. Culture of material from the infant's nose, throat and stool showed no organisms not normally present.

COMMENT

On admission the infant was observed to be critically ill, and a provisional diagnosis of congenital cardiac disease of the potentially cyanotic group was made. The mild cardiac enlargement and heart murmur made this diagnosis seem reasonable. After being placed in the oxygen tent the infant passed a black, watery stool. This, coupled with the chocolate color of the blood, led to the suspicion of methemoglobinemia due to nitrites derived from bismuth subnitrate. More detailed questioning of the parents brought forth the history of medication with a white powder which the dispensing pharmacist stated to be bismuth subnitrate. Because of the emphasis that has been placed on the role of methylene blue in forming methemoglobin to account for the antidotal action of this compound in cyanide poisoning [4] the value of such treatment was not at once realized in this instance. A transfusion of resuspended red cells was given in the hope of increasing the amount of functioning, circulating hemoglobin. The increase in the cyanosis subsequent to this transfusion led to a rapid reconsideration of the pathologic physiology of methemoglobinemia; it became apparent that the newly infused hemoglobin was rapidly converted to methemoglobin, thereby further intensifying the cyanosis. The institution of methylene blue therapy led to the previously noted excellent results.

7. This presence of a common group in these drugs was first called to our attention by Dr. Leo Dickison of the Department of Pharmacology at Vanderbilt University School of Medicine.

From the Infants' and Children's Hospitals.

1. Benncke: First Fatal Case of Bismuth Subnitrate Poisoning Reported in the Literature, München. med. Wchnschr. **53**: 945, 1906; cited by Beck, E. G.: Toxic Effects from Bismuth Subnitrate, J. A. M. A. **52**: 14 (Jan. 2) 1909. Boehme, A.: Nitrite Poisoning from the Internal Administration of Bismuth Subnitrate, Arch. f. exper. Path. u. Pharmakol. **57**: 441, 1907. Novak, J., and Gutig, C.: Nitrite Poisoning Because of Bismuth Subnitrate, Berl. klin. Wchnschr. **45**: 1764, 1908. Roe, H. E.: Methemoglobinemia Following the Administration of Bismuth Subnitrate, J. A. M. A. **101**: 352 (July 29) 1933. Miller, R. C.: Methemoglobinemia Occurring in a Case of Chronic Ulcerative Colitis, Proc. Staff Meet., Mayo Clin. **19**: 308 (June 14) 1944. Miller, G. E.: Bismuth Subnitrate Poisoning and Methemoglobinemia, Gastroenterology **4**: 430 (May) 1945.

2. Useful Drugs, ed. 9, Chicago, American Medical Association, 1934.

3. Analysis of the blood for methemoglobin was made by Dr. Clement Finch of the Peter Bent Brigham Hospital.

4. Wendel, W. B.: Methylene Blue, Methemoglobin, and Cyanide Poisoning, J. Pharmacol. & Exper. Therap. **54**: 283 (July) 1935.

It has been shown that under certain circumstances [5] nitrates are reduced to nitrites by the intestinal flora. The absorption of the nitrite so formed results in the conversion by oxidation of the iron in the hemoglobin molecule from the ferrous to the ferric state with the formation of methemoglobin, a non-oxygen-carrying pigment. The kinetics of this reaction have been studied by Darling and Roughton.[6] These investigators have shown that, in addition to the inactivation of a fraction of the oxygen-carrying power of hemoglobin, further physiologic disadvantage occurs because of a decided shift to the left of the oxygen saturation curve of the remainder of the functioning hemoglobin. After a given dose of nitrite there is a spontaneous reconversion of methemoglobin to hemoglobin within eight to nine hours.[7] However, the critical period of anoxia which may lead to death in a few hours warrants the use of methylene blue to hasten the reconversion. Poisoning with nitrites, unlike the methemoglobinemia of so-called enterogenous cyanosis and aniline poisoning, results in a rapid course of events. Physiologically, this is analogous to the effects of rapid hemorrhage versus slow loss of blood. The former is the more likely to end in a lethal occurrence. Ascorbic acid has recently been advocated [8] as superior to methylene blue in the treatment of methemoglobinemia. The effect of ascorbic acid in reversing the equilibrium between methemoglobin and oxyhemoglobin is slow, requiring ten to twelve hours at least, while methylene blue exerts its action in a matter of minutes.[9] In acute poisoning with nitrites death may occur before the antidotal action of ascorbic acid can take place. Ascorbic acid is of value, however, in the treatment of poisoning by such substances as aniline, in which the methemoglobin is continually formed from a given dose over a period of days.

Under certain conditions, as Warburg [10] has shown, methylene blue may form methemoglobin. For this reason its use has been recommended in the treatment of cyanide poisoning by Wendel,[4] and a general belief has become current that its use is contraindicated in methemoglobinemia. Wendel has investigated, in vivo, the clinical action of methylene blue in methemoglobinemia when the drug is used in low concentrations and has thoroughly validated its usefulness. He has advanced the view that the tissues of the body, other than the erythrocytes, rapidly convert methylene blue to the leuko form in which it is a capable reducing agent; the latter form then returns to the erythrocytes to reduce the methemoglobin to hemoglobin.

The toxic effects of methylene blue have been reviewed by Wendel.[7] The effective and safe dosage of the drug is 1 to 2 mg. per kilogram of body weight when given intravenously. The oral dosage is estimated to be approximately ten times the intravenous dose. At such dosage levels toxic effects are not to be expected. The required dose should be given slowly and diluted with 5 per cent dextrose or with isotonic solution of sodium chloride. Paravenous injection is to be avoided. For intravenous use the drug is marketed in a 1 per cent sterile solution in ampules. When the drug is given intravenously the cyanosis generally disappears in fifteen to thirty minutes; [11] with oral dosage the improvement may be delayed several hours. The rapid oral action in the reported case may possibly be attributed to the increased permeability of the gastrointestinal tract associated with diarrhea, in addition to the known rapid turnover of body fluids in the infant. In acute poisoning due to nitrite the wisest course would seem to be the immediate oral administration of methylene blue at a dosage of 10 to 20 mg. per kilogram of body weight to cover the period of obtaining, preparing and administering the drug by the intravenous route. The latter procedure may be time-consuming and not immediately available. Death from anoxia may quickly follow the onset of the cyanosis.

5. Zobell, C. F., and Myer, K. F.: Factors Influencing the Reduction of Nitrates by Bacteria in Semi-Solid Media, J. Bact. **24**: 273 (Oct.) 1932; Reduction of Nitrates and Nitrites by Representatives of the Brucella Group, Proc. Soc. Exper. Biol. & Med. **29**: 116 (Nov.) 1931. van den Bergh, A. A. H.: Enterogenous Cyanosis, Deutsches Arch. f. klin. Med. **83**: 86, 1905.

6. Darling, R. C., and Roughton, F. J. W.: The Effects of Methemoglobin, Am. J. Physiol. **137**: 56, 1942.

7. Wendel, W. B.: The Control of Methemoglobinemia with Methylene Blue, J. Clin. Investigation **18**: 179 (March) 1939.

8. Carnrick, M.; Polis, B. D., and Klein, T.: Methemoglobinemia: Treatment with Ascorbic Acid, Arch. Int. Med. **78**: 296 (Sept.) 1946.

9. Shortly after the admission of the infant whose case is reported herein, a member of the technical staff of the pathology department of the hospital swallowed an unknown amount of sodium nitrite, mistaking it for sodium bicarbonate. Approximately two hours later he became nauseated, felt dizzy and vomited, and intense cyanosis developed. He was unable to move about without syncope. Seventy-five milligrams of methylene blue was given intravenously in a period of five minutes. Before the end of the injection he noted the cessation of a sensation of "drumming" in the ears and relief from a sensation of pressure within the chest. Twenty minutes later he was free from all signs of cyanosis and was able to walk about freely without feeling faint.

10. Warburg, O.; Kubowitz, F., and Christian, W.: On the Catalytic Action of Methylene Blue in Living Cells, Biochem. Ztschr. **227**: 245, 1930.

11. Warburg, Kubowitz and Christian.[9] Wendel.[7]

SUMMARY

1. A case of acute methemoglobinemia in a 5 week old infant given bismuth subnitrate for diarrhea is reported.

2. The danger that the administration of bismuth subnitrate may cause methemoglobinemia is stressed.

3. The use and antidotal action of methylene blue in methemoglobinemia is discussed.

Council on Pharmacy and Chemistry

NEW AND NONOFFICIAL REMEDIES

The following additional articles have been accepted as conforming to the rules of the Council on Pharmacy and Chemistry of the American Medical Association for admission to New and Nonofficial Remedies. A copy of the rules on which the Council bases its action will be sent on application.

AUSTIN SMITH, M.D., *Secretary.*

CHORIONIC GONADOTROPIN (See New and Nonofficial Remedies, 1946, p. 470).

The following dosage forms have been accepted:

LAKESIDE LABORATORIES, MILWAUKEE

Choriogonin *(Powder)*.

Choriogonin 100 International Units and 500 International Units: 1.5 cc. vials. Vials containing a powdered preparation of chorionic gonadotropin with urea and sodium phosphate which when diluted with the accompanying 1.5 cc. of sterile distilled water, containing 0.5 per cent phenol, provide a solution having a potency of 100 or 500 international units per cubic centimeter.

Choriogonin 1,000 International Units, 5,000 International Units and 10,000 International Units: 10 cc. vials. Vials containing a powdered preparation of chorionic gonadotropin with urea and sodium phosphate which when diluted with the accompanying 10 cc. of sterile distilled water, containing 0.5 per cent phenol, provide a solution having a potency of 1,000 5,000 or 10,000 international units per cubic centimeter.

U. S. trademark 419,102.

CONTRACEPTIVE JELLIES AND CREAMS (See New and Nonofficial Remedies, 1946, p. 360).

The following article has been accepted:

JULIUS SCHMID, INC., NEW YORK

Ramses Vaginal Jelly: 92 Gm. collapsible tubes. A water soluble jelly formed from carboxymethylcellulose and glycerin having a p_H of 4, prepared from the formula:

Dodecaethylene glycol monolaurate	5.00%
Boric acid	1.00
Alcohol	5.00
Carboxymethylcellulose	2.50
Glycerin	9.00
Butyl parahydroxybenzoate	0.02
Perfume	0.01
Water to make	100.00

Packaged with a Ramses Vaginal Applicator or in refill packages containing a tube of jelly only.

U. S. trademark 306,696.

Ramses Vaginal Applicator: A transparent plastic tube threaded at the blunt intravaginal end to screw onto the tubes of Ramses Jelly to permit filling by compression. A plastic cylinder fitted inside the tube permits the operator to expel the jelly. The full capacity is 5 cc., the recommended dose.

U. S. patents 1,918,706 and 2,077,176.

PENICILLIN TROCHES (See THE JOURNAL, March 22, p. 851).

The following dosage form has been accepted:

BRISTOL LABORATORIES, INC., NEW YORK

Troches Penicillin Calcium: 1,000 units.

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SATURDAY, APRIL 26, 1947

THE TEACHING OF NUTRITION—I

Most physicians are now well aware of the importance of nutrition and believe it should be given greater attention in the teaching of medicine. Since the curriculum is full, however, the proposal does not demand establishment of a new division or the segregation of nutrition in a single department. While the fundamentals of medicine are being taught by the physiologist and the biochemist, the practical application of the science of nutrition may be integrated with the teaching conducted in the clinical branches. Consideration of nutrition is just as important in surgery [1] as in medicine and pediatrics; in obstetrics [2] its importance transcends many other factors.

Pellagra, sprue, beriberi, scurvy and the other deficiency diseases are probably receiving adequate attention, but these disorders are of minor importance compared with the borderline states of nutritive failure. Inadequate nutrition is related to vague ill health and retardation of recovery from many diseases. Recognition of such inadequacies depends not on laboratory technics but rather on the clinical acumen of the physician. Most clinicians have seen the mental depression, lack of initiative and loss of efficiency that accompany nutritive deficiency and the "neurasthenia" in patients who a year later developed frank pellagra.[3] Nutritional neuropathies have been described recently in internees and prisoners of war who lived on grossly deficient diets.[4] Nutrition definitely modifies the course of such diverse diseases as typhoid, peptic ulcer and cirrhosis of the liver.

The student must be taught to recognize these conditions. He must learn to keep in mind the nutritive status when he looks at the patient, at the eyes, the tongue, the gums, the skin and the bony contour. He must remember the importance of nutrition as he tests the reflexes and evaluates nervous stability. He must recognize the heavy draft that infectious and other diseases make on the patient's nutritional resources. He must realize that he can frequently hasten recovery by giving thought to the state of nutrition. If he is interested in the comfort and happiness of those who look to him for advice he must learn that the words adequate and optimum as applied to diet are not synonymous. By giving appropriate advice he can do his part in contributing to the happiness of the patient and ultimately to the improvement of the race.[5]

The Council on Foods and Nutrition emphasizes the importance of a knowledge of nutrition in scientific medicine. The problem, as the Council sees it, is to induce teachers of medicine to weave a heavier design of this relatively new subject into the already tight fabric of daily teaching.

1. Lund, Charles C., and Levenson, Stanley M.: Protein in Surgery, J. A. M. A. **128**: 95 (May 12) 1945.
2. Ebbs, J. H.: Nutritive Requirements in Pregnancy and Lactation, J. A. M. A. **121**: 339 (Jan. 30) 1943.
3. McLester, J. S.: Nutrition and Diet, ed. 4, Philadelphia, W. B. Saunders Company, 1934, p. 335.
4. Clarke, C. A., and Sneddon, I. B.: Nutritional Neuropathy, in Prisoners of War and Internees from Hong Kong, Lancet **1**: 734 (May 18) 1946.
5. Sherman, H. C.: The Expanding Opportunity of the Science of Nutrition, Nutrition Rev. **4**: 225 (Aug.) 1946.

ACQUIRED PENICILLIN RESISTANCE OF TREPONEMA PALLIDUM

The question as to whether or not Treponema pallidum may develop an acquired resistance to penicillin is of clinical and epidemiologic interest. Kolmer and Rule [1] of the Philadelphia Research Institute of Cutaneous Medicine have produced experimental evidence against this acquired tolerance.

In their experiments rabbits were inoculated intratesticularly with the Nichols-Hough strain of T. pallidum. About five weeks later all inoculated rabbits showed acute syphilitic orchitis with strongly positive dark field findings. The minimum curative dose of a commercial penicillin, given in aqueous solution by three intramuscular injections for ten doses, was between 1,000 units per dose, a total dose of 10,000 units per kilogram, and 5,000 units per dose, or a total dose of 50,000 units per kilogram. Rabbits given less than 10,000 units (e. g. a total dose of 4,500 to 9,000 units per kilogram) showed a temporary clinical improvement with negative dark field findings in from seven to fourteen days. This was followed by a relapse with positive dark field findings.

At the end of three weeks a second group of rabbits was inoculated intratesticularly with testicular material from these relapsed animals. All developed acute syphilitic orchitis with positive dark field findings. These animals were then given a subcurative dose of penicillin. All of this group showed clinical improvement with negative dark field findings about seven days after treatment but relapsed clinically about two weeks later. A week later a third group of rabbits was inoculated

1. Kolmer, J. A., and Rule, Anna M.: Proc. Soc. Exper. Biol. & Med. **63**: 240 (Nov.) 1946.

intratesticularly with material from this second relapsed group. These animals were similarly treated with a subcurative dose of penicillin. The reinoculation was repeated through a fourth group.

Material from the fourth relapsed group was inoculated into a large fifth group. The minimum curative dose of penicillin was redetermined on this group. Rabbits of this group given a total dose of between 10,000 and 50,000 units per kilogram became permanently negative. The total cure was confirmed by lymph node transfer. Within the limits of the experimental error the results were identical with therapeutic titrations on control rabbits inoculated with the original infectious material. From this Kolmer concludes that T. pallidum does not show evidence of an acquired resistance to penicillin after three consecutive passages through the testicles of rabbits treated with subcurative amounts of commercial penicillin.

This conclusion is in accord with previous conclusions by Tung and Frazer,[2] who found that cultures of T. pallidum did not develop evidence of increased resistance to penicillin after being subjected to fifteen passages through mediums containing substerilizing concentrations of this compound.

PRIMITIVE FAT ORGANS

Two theories prevail concerning the histogenesis of the fat cell. According to one, it is a cell set apart in early life for the purpose of producing fat, so-called primitive fat "organs" being found in various localities in the form of small groups of stellate or spindle cells richly permeated by capillary vessels. The other theory accounts for the origin of the fat cell on the basis of metaplasia of the fibroblast with accumulation of fat within its body. The fibroblast, when it fails to take on the specialized function of the fat cell, it is assumed, follows its natural inclination and develops into connective tissue. Probably both methods of cellular lipogenesis are effective. In certain pathologic conditions the primordial fat "organs" are increased in size because of hyperplasia of their cellular constituents; inversely, in many cachectic subjects the fat disappears from the cell and the cytoplasm is replaced by serous fluid in the epicardial and perirenal tissues, the cell reverting to the polygonal form of the embryonal unit —so-called serous atrophy of fat. Identical reversionary changes may be produced experimentally in fat tissues by prolonged starvation, but if the animal is given carbohydrate the fat is replaced in the cell body. In the bodies of marantic infants bright cherry-red primitive fat "organs" may sometimes be found in chains or trellis-like formations over such a wide distribution as to resemble a disseminated new growth, especially in intermuscular fascial planes, in the loose connective tissues around the larynx, the esophagus and the thyroid gland, behind the sternum, in the precordial area and around the kidneys. In other circumstances, notably in a wide variety of chronic productive inflammatory lesions attended by overgrowth of fibroblasts, the transformation may be observed of young connective tissue elements into cells indistinguishable from those of the primitive fat "organs."

In 1915 Pende [1] described what he believed to be a gland of internal secretion belonging to the endocrine system (glandula insularis cervicalis). He found it in children and in puppies as solid islands of cells which he assumed to be of epithelial nature. However, it is now generally accepted that the structures described by Pende are identical with primitive fat "organs."

The interscapular or hibernating gland of Merkle is a paired fat "organ" which extends over a considerable area in the region of the shoulders and the sides of the neck. It is constant in mammals, and in man it is probably the homologue of the hibernating gland of rodents. Shattock,[2] referring to the hibernating gland of the hedgehog, states that "during hibernation these reserves are used up and dwindle away, a residuum of connective tissue alone remaining, to be again replaced before the arrival of the next hibernating season." Others believe that the fat in these localities is not disturbed during hibernation or starvation. However true this may be, apparently sound opinion holds that the hibernating or interscapular gland is an organ primarily set apart for the storage of fat. The clinical significance of embryonal fat cells is further exemplified in a disease described by Whipple [3] that is characterized by gradual loss of weight and strength, by the presence of abundant neutral fat and fatty acids in the stools and by a variety of fugitive arthritis involving multiple joints. Anatomically, the intestinal villi were enlarged because of extensive deposits in the lymph spaces of neutral fats and fatty acids together with infiltration of the interglandular connective tissues by cells which are morphologically identical with embryonal fat cells. The submucous connective tissues and the mesenteric lymph nodes were similarly affected. Since the appearance of Whipple's paper 7 cases of this description have been reported.[4] Finally, Inglis [5] has described a tumor derived from the polygonal fat cells of the interscapular gland, and Symmers [6] has recorded a spindle and giant cell sarcoma arising presumably from the connective tissues of the intrathoracic primitive fat "organs."

2. Tung, Tsun, and Frazer, C: N.: Am. J. Syph., Gonor. & Ven. Dis. **30:** 205 (May) 1946.

1. Pende, N.: Ueber eine neue Drüse mit innerer Sekretion (Glandula insularis cervicalis), Arch. f. mikr. anat. **86** (1, Abt.): 193, 1914.

2. Shattock, S. G.: On Normal Tumor-like Formations in Man and the Lower Animals, Proc. Roy. Soc. Med. **2:** 207 (path. sec.) 1908-1909.

3. Whipple, G. H.: A Hitherto Undescribed Disease Characterized Anatomically by Deposits of Fat and Fatty Acids in the Intestinal and Mesenteric Lymphatic Tissues, Bull. Johns Hopkins Hosp. **18:** 382, 1907.

4. Fitzgerald, P. J., and Kinney, T. D.: Intestinal Lipodystrophy (Whipple's Disease), Am. J. Path. **21:** 1069 (Nov.) 1945.

5. Inglis, K.: So-Called Interscapular Gland and Tumors Arising Therein, J. Anat. **81:** 452 (July) 1927.

6. Symmers, Douglas: Spindle and Giant Cell Sarcoma Arising from Unidentified Precordial Bodies, Arch. Path. **37:** 180 (March) 1944.

Current Comment

EOSINOPHILIC GRANULOMA OF BONE

In 1940 a granulomatous bone lesion was described by Otani and Ehrlich [1] and by Lichtenstein and Jaffe,[2] who named it eosinophilic granuloma of bone; the disease is now well established under that name. Recently three reports [3] of 10 new cases were published, bringing the number of reported cases to 63, most of them from this country. Consequently the granuloma should be considered in the diagnosis of bone diseases, especially those of localized nature occurring in the early decades of life. Briefly stated, this condition is a more or less self-limited osteolytic, granulomatous process of unknown but possibly infectious nature. In the early stages eosinophilic leukocytes dominate the cellular picture of the lesion; later vacuolated mononuclear cells—foam cells—are more characteristic; healing takes place by fibroblastic proliferation and regeneration of bone. The disease may occur in any part of the skeleton proximal to the wrists and ankles. The lesion, more frequently single than multiple, appears to extend from the marrow. Usually the x-rays show a round, oval or irregular area of decreased density and 1 to 4 cm. in diameter. There may be some fever with leukocytosis and also local tenderness, pain and swelling of the soft tissues over the bone lesion. The natural course runs from a few months to a year or more. In single lesions the prognosis seems good even without treatment. Surgical excision, curettage and x-ray treatment have been effective. Most cases appear to heal under the x-rays. Concerning the diagnosis and treatment of eosinophilic granuloma of bone, Dundon, Williams and Laipply [3] say "Because the x-ray appearance of eosinophil granuloma may be indistinguishable from other inflammatory lesions, multiple myeloma or metastatic tumor, a biopsy is usually indicated. Thus, in most cases, the treatment of choice is probably either complete curettage or curettage followed by irradiation." A death from eosinophilic granuloma has not been recorded. Neither have any visceral lesions been described, a curious feature inviting close study. As indicated in the title of the comprehensive paper by Lichtenstein and Jaffe,[4] the mononuclear cells in the intermediate stages of the eosinophilic granuloma suggest a relationship to Letterer-Siwe disease and to the Schüller-Christian syndrome, each associated with a peculiar inflammatory histiocytosis, of which the granuloma may be the mildest clinical manifestation. Dundon, Williams and Laipply mention the occurrence of granuloma in a 17 year old girl; mild symptoms persisted for twenty-eight months and more after the onset, and there was mediastinal lymph node involvement in addition to a lesion of the sternum. Close study of such cases may throw light on the relation of eosinophilic granuloma of bone to extraskeletal and other forms of morphologically similar granulomatous processes.

1. Otani, Sadao, and Ehrlich, J. C.: Solitary Granuloma of Bone Simulating Primary Neoplasm, Am. J. Path. **16:** 479 (July) 1940.
2. Lichtenstein, Louis, and Jaffe, H. L.: Eosinophilic Granuloma of Bone, with Report of a Case, Am. J. Path. **16:** 595 (Sept.) 1940.
3. Dundon, C. C.; Williams, H. A., and Laipply, T. C.: Eosinophilic Granuloma of Bone, Radiology **47:** 433 (Nov.) 1946. Hamilton, J. B., and associates: The Osseous Manifestations of Eosinophilic Granuloma, ibid., p. 445. Riley, P.: Eosinophilic Granuloma of Bone: Report of a Case with Preoperative Roentgen Diagnosis, ibid., p. 514.
4. Lichenstein, Louis, and Jaffe, H. L.: Eosinophil Granuloma of Bone: A Condition Affecting One, Several or Many Bones but Apparently Limited to the Skeleton and Representing the Mildest Clinical Expression of the Peculiar Inflammatory Histiocytosis Also Underlying Letterer-Siwe Disease and Schüller-Christian Disease, Arch. Path. **37:** 99 (Feb.) 1944.

UVEAL SARCOMAS

A study [1] of 263 cases of uveal sarcomas has revealed that males and females were about equally affected, the average age was approximately 52 years (with a range from 1½ years to 87 years), and people in the sixth decade were most prone to develop the disease. Martin-Jones found few etiologic factors. Although there were many cases in the series with a previous history of trauma, injury was a doubtful predisposing cause. A definite history of trauma was present in 6.4 per cent, an incidence of injury which is in agreement with 8.26 per cent for 1,439 cases of tumors of the eye and orbit observed at the Mayo Clinic. However, the British investigator feels that previous choroidal hemorrhages and old pigmentary changes in the fundus are only occasionally predisposing factors. Abnormal aggregations of pigment both in the choroid and in the iris may undergo malignant transformation. From a clinical diagnostic point of view the majority of the patients in this series presented themselves for examinations with vision reduced to perception of light or complete blindness. Fifty per cent had an increased intraocular tension. Retinal detachment without a "hole" was present in every case. The majority of the tumors were in the posterior part of the globe. Spindle cell tumors were the commonest variety, and epithelioid growths uncommon. Enucleation is, of course, the best treatment. In this series 27 per cent of the patients died within three years of operation, 36 per cent within five years and 56 per cent within ten years. The prognosis was bad in those cases in which melanogen was present in the urine and in patients in whom extraocular extension had taken place.

1. Martin-Jones, J. D.: Uveal Sarcomata, Brit. J. Ophth., Monograph Supplement XI, 1946.

LOBECTOMY BRINGS LOW MORTALITY

Although the operation of lobectomy has been performed for many years, its value and the low operative mortality of the procedure may not be fully appreciated. Recently, Meade and his colleagues [1] discussed results of 236 lobectomies performed at the Kennedy General Hospital between November 1943 and May 1946. Lobectomy was performed for bronchiectasis, pulmonary cyst, chronic suppuration, bronchial adenoma, adenomatosis, tuberculosis, neurogenic sarcoma and actinomycosis. Bronchiectasis was by far the most common indication. Only 1 patient died. This report offers a splendid illustration of the effectiveness and especially of the safety of lobectomy as performed today.

1. Meade, Richard H. Jr.; Kay, Earle B., and Hughes, Felix A.: A Report of 196 Lobectomies Performed at Kennedy General Hospital Chest Surgical Center from 1943 to 1946 with One Death, J. Thoracic Surg. **16:** 16 (Feb.) 1947.

V 1
194

ORGANIZATION SECTION

Medical Economics

THE TREND TOWARD LABOR HEALTH AND WELFARE PROGRAMS

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The health of trade union members has been a subject for union interest ever since 1893. True, extensive health insurance programs as are now being advocated are of comparatively recent development but only as far as they are considered issues related to collective bargaining. Provision for the financial protection of members against wage losses due to illness was among the earliest beneficial activities of trade unions. The barbers, who were organized in 1887, offered sick benefits to their membership in 1893. The tobacco workers and pattern makers provided such benefits as early as 1896. However, the whole history of union sickness benefits has been a troubled one. Many of the plans were begun on an inadequate financial basis. The following is a quotation from a bulletin recently released by the American Federation of Labor regarding the early health benefit plans: "Unions have sponsored their own benefit plans for decades. Often actuarially unsound, and overambitious in scope, many of these plans collapsed."[1] In 1933 twenty unions reported payments of sickness benefits. In 1943 there were eighteen such reports.

What, then, brought about the renewed interest in health and welfare programs, and when did they start their swing into the labor limelight?

The inclusion of health and welfare programs in labor contracts is a wartime development. During the period of the wage stabilization program efforts were made to secure "fringe benefits" in addition to proposed wage increases. The War Labor Board acted kindly toward proposals for sickness pay and approved complete health protection programs if the employer was agreeable; more often than not he was. This gave stimulus to the growth of the plans. Last year a Bureau of Labor Statistics bulletin gave a total of 600,000 as the number of workers covered by collective bargaining agreements which provide for some type of accident or sickness insurance. Just recently Boris Stern, chief of the Industrial Relations Branch of the Bureau of Labor Statistics, estimated that more than a million and a quarter wage earners are covered by agreements which have provisions of that kind.[2] The number is steadily increasing.

In the men's clothing industry 270,000 workers get health benefits. The textile industry covers 150,000; ladies' garment workers 200,000. The laundry, cleaning and dyeing industry covers 30,000. Walter Reuther has just announced a proposal for his 800,000 automobile workers. This is not just a wartime boom. It has real and permanent postwar potentialities.

The aims for inclusion of sick benefit programs within the framework of the collective bargaining agreement are threefold. The American Federation of Labor has announced the advantages of such programs as follows:

1. The individual union member is protected against the expenses of unforeseen accidents, sickness and loss of pay—the primary purpose of the program.

2. The union gains new prestige in the eyes of the old members, prospective members and rival union members. Thus, loyalty is secure from within, expansion made easier and raiding by dual unions made difficult.

3. The employer will find improved morale and increased cooperation among his employees. Labor turnover is decreased, thus stabilizing the labor force.

With respect to this last advantage, we cannot be certain that all employers will greet the union proposed plans with enthusiasm. In the past many employers sponsored mutual benefit associations as part of an "open shop" device to counteract unionism. Recent employer reaction has ranged from hearty enthusiasm to casual acceptance and, in the case of the coal mine operators, bitter opposition. It is difficult to distinguish between an employer's attitude toward sickness benefits as such and his attitude toward his whole collective bargaining situation. However, the general attitude toward the programs has not been hostile. It will be interesting to watch the response of the automobile manufacturers this spring to Walter Reuther's proposed social security and health benefit program.

The plans which are now in effect have certain general characteristics. First, with respect to benefits provided:

All the benefits are for nonoccupational disabilities. These are (1) weekly cash benefits during periods of illness or of disability caused by accidents, (2) hospital benefits, (3) surgical benefits, (4) maternity benefits and (5) benefits for accidental death, dismemberment and loss of eyesight and (6) several plans which now provide cash benefits for doctors' services.

Many of the plans include weekly disability benefits ranging from 50 to 60 per cent of the employee's regular earnings; other plans provide from $10.50 to $20 a week. Payments for hospital services range from $4 to $5 a day for thirty-one days. Maximum surgical benefits usually range from $100 to $175. A few plans allow specified payments for doctors' services up to a maximum of fifty visits for any one disability. Many programs provide service benefits through the Blue Cross Associated Hospital Service. The general practice has been, however, to provide only cash indemnity payments.

Eligibility requirements for benefits are usually that the worker be employed by a contributing employer and be in good standing in his union. A certain minimum period of employment is usually specified in those plans which are administered by insurance companies.

An important aspect of the programs is the manner in which they are administered. There are three main types of administration: (1) administration by a private insurance company, (2) administration solely by the union and (3) administration jointly by the union and the employer.

Even when the plan is underwritten by a private stock or mutual insurance company, the union and the employers frequently share in the responsibility of administration. A study made and published by the Industrial Relations Section of Princeton University stated that the health and welfare programs now in effect are predominantly union administered. Claims are generally filed through the union office. In some instances benefit payments are made directly by the insurance company. In other plans payments are made through the union office.

In those plans which are to be administered by the insurance company the benefits and coverage are determined through collective bargaining. The employer is then free to contract for such coverage with any company he chooses. It is quite common for the union to have a voice in the day to day administration. Some unions appoint shop committees to adjust individual complaints and grievances and see that the employer is paying the necessary premiums to the insurance company. Some of the unions which already have such plans are C. I. O. and A. F. L. textile workers, American Federation of Hosiery Workers, United Fur and Leather Workers, hotel and restaurant employees and street and electric railway employees.

The union administered benefit plans are financed entirely by the employer or employers who agree to pay a stipulated amount—usually a percentage of the payroll to a benefit fund

From the Bureau of Medical Economic Research.

Excerpts from an address before the Annual County Secretaries and Public Relations Conference, Michigan State Medical Society, Detroit, Feb. 2, 1947.

1. American Federation of Labor; Health Benefit Plans by Collective Bargaining, Collective Bargaining Series No. 1, May 25, 1946.

2. Stern, Boris: Horizons in Industrial Health and Welfare, J. A. M. A. 132:760 (Nov. 30) 1946.

133
947

established within the union. The International Ladies' Garment Workers Union, the New York City Laundry Workers and the United Hatters, Cap and Millinery Workers all have such plans.

Jointly administered plans are not quite so common. Examples are the Amalgamated Clothing Workers and the United Retail, Wholesale and Department Store Employees. The Amalgamated as far back as 1926 had arrangements whereby union members could receive careful medical examination and advice on health matters.

The great majority of the plans are financed entirely by the employers. The usual method is for the employer to pay a certain percentage of his pay roll. The most elaborate plans are financed by a "tax" or "royalty" on the employer's pay roll or sales revenue, with the union or a joint board of union-employer representatives possessing control over administration of the funds accumulated. Also widely employed is the directly negotiated insurance type plan which lends itself well to contracts covering a small number of employees. Usually the plan requires the employer to secure specific benefits stipulated in the agreement through insurance companies approved by the union, with the employer bearing some or all of the cost. In such cases a fixed pay roll tax is uncommon. Once the specific benefits have been written into the agreement and the insurance company is selected, the administration is no problem.

In bargaining for the pay roll percentage contribution method of financing the benefits, the question of the employer's ability to pay often arises. The unions claim that the fixed pay roll tax is advantageous as a method of employer financing since the costs are more likely to remain constant under this method than they are when the employer selects his own policy and administers the policy stipulated in the labor agreement. The employer who contributes a percentage of his pay roll would not be directly affected by increases in insurance company rates. This advantage, of course, presupposes a constant pay roll—which may or may not be the case.

In the United Mine Workers' Health Fund the agreement provides for a 1.5 per cent pay roll tax which is to be put into one special health fund. Out of this fund will be made payments for illness and disability, the nature of which has not yet been determined. It is not an insurance plan such as has been outlined. In fact, there is no present agreement as to just how any of the money which is to be accumulated in this fund will be distributed. Here is an example of union administration without provision for a private insurance company to underwrite the plan.

There are many problems which must still be faced in the development of union health and welfare programs. There are many types of programs in effect and many new kinds which are being advocated. A single ideal program cannot be evolved to meet equally the needs of different employee groups. Insurance agents have warned the unions that the plans must have a sound actuarial basis or that they will soon disintegrate because of their own inherent weaknesses. Occupation, age and sex of the group must be considered in developing the plan, and problems of administration should be carefully considered.

As far as the relation of the plans to public health insurance is concerned, it is felt that the unions have, at least temporarily, given up the idea of the government providing them with sickness insurance. Walter Reuther has said "There is no evidence to encourage the belief that we may look to Congress for relief. In the immediate future, security will be won for our people only to the extent that the union succeeds in obtaining such security through collective bargaining." [3] The aims of practical "here and now" unionism are being put into effect without waiting for the government to launch any cumbersome compulsory sickness insurance program. Union leaders are fast realizing the practicality of smaller scale plans, geared to their own particular needs, and administered for their own particular interests.

3. Reuther, Walter: Letter sent to local union presidents of United Automobile Workers—C. I. O.: Announcement of U. A. W.-C. I. O. Social Security Insurance Program, Nov. 15, 1946.

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Bureau of Labor Statistics, U. S. Department of Labor: Health Benefit Programs Established Through Collective Bargaining, Bull. 841, 1945.

Council on Medical Service and the Council on Industrial Health: Report to the San Francisco Session of the House of Delegates on National Bituminous Coal Mine Wage Agreement, J. A. M. A. **132:** 453 (Oct. 26) 1946.

Council on Medical Service: Report to Reference Committee on United Mine Workers' Health Fund, ibid. **132:** 1012 (Dec.) 1946.

Health and Welfare in Employment Contracts, Current Comment, ibid. **132:** 788 (Nov.) 1946.

Industrial Relations Section, Princeton University: Group Health Insurance and Sickness Benefit Plans in Collective Bargaining, Princeton, N. J., 1945.

Millis, Harry A., and Montgomery, Royal E.: Labor's Risks and Social Insurance, New York, McGraw Hill Book Company, 1938.

Medical Legislation

STATE LEGISLATION

Colorado

Bill Passed.—H. 895, which passed the senate April 3, proposes to appoint the Colorado State Department of Public Health as the sole agency for carrying out the purpose of the **federal hospital construction act** and to require the governor to appoint a state advisory hospital council.

Delaware

Bill Enacted.—S. 225, which was approved April 5, provides for the establishment of a state **health and welfare clinic** and health center chiefly for children.

Kansas

Bill Passed.—H. 102, which passed the senate April 4, proposes to require all persons applying for **a marriage license** to present a certificate signed by a physician legally qualified under the laws of the state of Kansas or of the state in which he is practicing that the applicant is not infected with syphilis in such a stage as to make it communicable to a marital partner.

Bills Enacted.—H. 67, which was approved April 8, provides for the licensing and **regulating of hospitals** within the state. H. 399, which was approved April 3, is a **hospital survey and construction act** requiring a survey of existing hospital facilities and the preparation of a program for the construction of additional needed facilities. The law also provides for the appointment of an advisory hospital council and authorizes the application for and receipt of federal funds to assist in the survey and construction activities of the state.

Minnesota

Bill Passed.—H. 882, which passed the senate April 9, proposes to prohibit **hospital employees** of a charitable hospital from encouraging, participating in or causing any strike or work stoppage against or directly involving such charitable hospital. A senate floor amendment of April 7 proposes that this restriction should apply also to all state, university, county and municipal hospitals.

New York

Bills Enacted.—S. 740, which has become chapter 422 of the Laws of 1947, amends the revocation provisions of the **medical practice act** by providing that nothing shall prohibit physicians from practicing medicine as partners nor in groups nor from pooling fees and monies received either by the partnerships or groups or by the individual members thereof for professional services furnished by any individual physician, member or employee of such partnership or group, nor shall the physicians constituting the partnerships or groups be prohibited from sharing, dividing or apportioning the fees and monies received by them or by the partnership or group in accordance with a partnership or other agreement. S. 741, which has become chapter 721 of the Laws of 1947, amends the section of the **medical practice act** relating to exemptions by providing that the terms of the act shall not prevent a corporation organized under article nine of the insurance law from employing duly licensed physicians or from entering into contracts with duly licensed physicians or with partnerships or groups of duly licensed physicians to practice medicine on its behalf for persons insured under its contracts or policies.

South Carolina

Bill Passed.—S. 254, which passed the house April 10, proposes to authorize **osteopathic physicians** licensed in the state to certify birth and death certificates in the same manner as is now prescribed by law for other physicians.

Texas

Bill Passed.—H. 217, which passed the house April 9, proposes, among other things, that any physician duly licensed under the laws of Texas to practice medicine who, when **an autopsy** is ordered by a justice of the peace, performs the autopsy in good faith in the belief that the order of the autopsy is a valid order, shall not be held liable for damages in the event it should be determined that the order of autopsy made by the justice of the peace was for any reason invalid.

Coming Medical Meetings

American Medical Association, Atlantic City, June 9-13. Dr. George F. Lull, 535 N. Dearborn St., Chicago 10, Secretary.

Aero Medical Association of the United States, Atlantic City, June 4-6. Dr. David S. Brachman, 1016 Dime Bldg., Detroit 26, Secretary.

American Association for Thoracic Surgery, St. Louis, May 28-30. Dr. Richard H. Meade Jr., 55 E. Washington St., Chicago 2, Secretary.

American Association of Genito-Urinary Surgeons, Absecon, N. J., June 4-6. Dr. Charles C. Higgins, 2020 E. 93d St., Cleveland 6, Secretary

American Association of Industrial Physicians and Surgeons, Buffalo, N. Y., Statler Hotel, April 26-May 4. Dr. Frederick W. Slobe, 28 E. Jackson Blvd., Chicago 4, Secretary.

American Association of Pathologists and Bacteriologists, Chicago, May 16-17. Dr. Howard T. Karsner, 2085 Adelbert Road, Cleveland 6, Secretary.

American Association of Plastic Surgeons, Nashville, Tenn., May 5-6 and Memphis, Tenn., May 7-8. Dr. Frederick A. Figi, 102 Second Ave. S.W., Rochester, Minn., Secretary.

American Association of the History of Medicine, Cleveland, May 25-26. Dr. Howard Dittrick, 2020 E. 93d St., Cleveland 6, Secretary.

American Association on Mental Deficiency, St. Paul, Minn., May 28-31. Dr. Neil A. Dayton, Box 51, Mansfield Depot, Conn., Secretary.

American College of Allergists, Atlantic City, Hotel Senator, June 6-8. Dr. Fred W. Wittich, 401 LaSalle Medical Bldg., Minneapolis 2, Secretary.

American College of Chest Physicians, Atlantic City, June 5-8. Mr. Murray Kornfeld, 500 N. Dearborn St., Chicago 10, Executive Secretary.

American College of Physicians, Chicago, April 28-May 2. Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Secretary.

American College of Radiology, Atlantic City, June 7-8. Mr. Mac F. Cahal, 20 N. Wacker Drive, Chicago 6, Executive Secretary.

American Dermatological Association, Murray Bay, Quebec, Can., June 1-5. Dr. Harry R. Foerster, 208 E. Wisconsin Ave., Milwaukee, Wis., Secretary.

American Federation for Clinical Research, Chicago, Hotel Sherman, April 28. Dr. Richard H. Lyons, University Hospital, Ann Arbor, Mich., Secretary.

American Geriatrics Society, Atlantic City, Hotel Brighton, June 5-7. Dr. Malford W. Thewlis, 25 Mechanic St., Wakefield, R. I., Secretary.

American Heart Association, Atlantic City, Hotel President, June 6-7. Dr. Howard B. Sprague, 50 W. 50th St., New York, Secretary.

American Medical Women's Association, Atlantic City, June 7-8. Dr. Helen F. Schrack, 216 N. Fifth St., Camden, N. J., Secretary.

American Neisserian Medical Society, Atlantic City, Marlborough-Blenheim Hotel, June 8. Dr. William L. Fleming, 750 Harrison Ave., Boston, Secretary.

American Neurological Association, Atlantic City, Ambassador Hotel, June 16-18. Dr. Walter O. Klingman, 195 Ft. Washington Ave., New York 32, Secretary.

American Ophthalmological Society, Hot Springs, Va., June 5-7. Dr. Walter S. Atkinson, 129 Clinton St., Watertown, N. Y., Secretary.

American Pediatric Society, Stockbridge, Mass., May 13-15. Dr. Henry G. Poncher, 1819 W. Polk St., Chicago 12, Secretary.

American Physiological Society, Chicago, May 18-22. Dr. Maurice Visscher, University of Minnesota, Minneapolis, Secretary.

American Proctologic Society, Atlantic City, June 7-8. Dr. Harry E. Bacon, 2031 Locust St., Philadelphia 3, Secretary.

American Psychiatric Association, New York, Hotel Pennsylvania, May 19-23. Dr. Leo H. Bartemeier, General Motors Bldg., Detroit, Secretary.

American Radium Society, Atlantic City, June 8. Dr. Hugh F. Hare, 605 Commonwealth Ave., Boston 15, Secretary.

American Society for Clinical Investigation, Atlantic City, Chalfonte-Haddon Hall, May 5. Dr. Eugene A. Stead Jr., Grady Hospital, Atlanta 3, Georgia, Secretary.

American Society for Experimental Pathology, Chicago, May 19-23. Dr. Frieda S. Robschlit-Robbins, 260 Crittenden Blvd., Rochester, N. Y., Secretary.

American Society for Pharmacology and Experimental Therapeutics, Chicago, May 18-22. Dr. Harvey B. Haag, Medical College of Virginia, Richmond 19, Va., Secretary.

American Society for Research in Psychosomatic Problems, Atlantic City, May 3-4. Dr. Edwin G. Zabriskie, 714 Madison Ave., New York 21, Secretary.

American Society for the Study of Sterility, Atlantic City, Hotel Shand, June 7-8. Dr. John O. Haman, 490 Post St., San Francisco 2, Secretary.

American Society of Biological Chemists, Chicago, May 18-22. Dr. Otto A. Bessey, Public Health Research Institute, New York 9, Secretary.

American Society of Clinical Pathologists, Atlantic City, June 4-8. Dr. Alfred S. Giordano, 531 N. Main St., South Bend, Ind., Secretary.

American Society of Electroencephalography, Atlantic City, Marlborough-Blenheim Hotel, June 13-14. Dr. Robert S. Schwab, Massachusetts General Hospital, Boston 14, Secretary.

American Therapeutic Society, Atlantic City, Chalfonte Hotel, June 6-7. Dr. Oscar B. Hunter, 1835 I St., N. W., Washington 6, D. C., Secretary.

Arizona State Medical Association, Tucson, May 7-10. Dr. Frank J. Milloy, 112 N. Central Ave., Phoenix, Secretary.

Association for the Study of Internal Secretions, Atlantic City, June 6-7. Dr. Henry H. Turner, 1200 N. Walker St., Oklahoma City 3, Secretary.

Association of American Physicians, Atlantic City, May 6-7. Dr. Joseph T. Wearn, Lakeside Hospital, Cleveland 6, Secretary.

California Medical Association, Los Angeles, Hotel Biltmore, April 30-May 3. Dr. L. Henry Garland, 450 Sutter St., San Francisco 8, Secretary.

Connecticut State Medical Society, New Haven, April 28-30. Dr. Creighton Barker, 258 Church St., New Haven 10, Secretary.

Federation of American Societies for Experimental Biology, Chicago, May 18-22. Dr. William H. Chambers, 1300 York Ave., New York 21, Secretary.

Hawaii Territorial Medical Association, Lihue, Kauai, May 1-4. Dr. Harry L. Arnold Jr., 510 S. Beretania St., Honolulu 53, Secretary.

Idaho State Medical Association, Sun Valley, June 16-19. Dr. William B. Handford, Caldwell, Secretary.

Illinois State Medical Society, Chicago, Palmer House, May 12-14. Dr. Harold M. Camp, 224 S. Main St., Monmouth, Secretary.

Kansas Medical Society, Topeka, May 12-15. Dr. John M. Porter, 512 New England Bldg., Topeka, Secretary.

Louisiana-Mississippi Ophthalmological and Otolaryngological Society, Biloxi, Miss., Buena Vista Hotel, May 5. Dr. Edley H. Jones, 1301 Washington St., Vicksburg, Miss., Secretary.

Louisiana State Medical Society, New Orleans, May 12-14. Dr. P. T. Talbot, 1430 Tulane Ave., New Orleans 13, Secretary.

Massachusetts Medical Society, Boston, Hotel Statler, May 20-22. Mr. Robert St. B. Boyd, 8 Fenway, Boston 15, Executive Secretary.

Medical Library Association, Cleveland, Wade Park Manor, May 27-29. Miss Heath Babcock, New York State Medical Library, Albany 1, New York, Secretary.

Mississippi State Medical Association, Biloxi, May 6-8. Dr. T. M. Dye, Box 295, Clarksdale, Secretary.

National Gastroenterological Association, Atlantic City, June 4-6. Dr. G. Randolph Manning, Room 319, 1819 Broadway, New York, Secretary.

National Tuberculosis Association, San Francisco, June 16-19. Dr. F. D. Hopkins, 1790 Broadway, New York 19, Executive Secretary.

Nebraska State Medical Association, Omaha, April 28-May 1. Dr. R. B. Adams, 416 Federal Securities Bldg., Lincoln 8, Secretary.

New Mexico Medical Society, Albuquerque, April 30-May 3. Dr. H. L. January, 221 West Central Ave., Albuquerque, Secretary.

New Hampshire Medical Society, Portsmouth, Hotel Wentworth, June 19-20. Dr. Carleton R. Metcalf, 5 South State Street, Concord, Secretary.

New York, Medical Society of the State of, Buffalo, May 5-9. Dr. Walter P. Anderton, 292 Madison Avenue, New York 19, Secretary.

North Carolina, Medical Society of the State of, Virginia Beach, Va., Cavalier Hotel, May 12-14. Dr. Roscoe D. McMillan, P. O. Box 232, Red Springs, Secretary.

North Dakota State Medical Association, Fargo, May 25-27. Dr. L. W. Larson, 221 Fifth St., Bismarck, Secretary.

Ohio State Medical Association, Cleveland, May 6-8. Mr. Charles S. Nelson, 79 E. State St., Columbus 15, Executive Secretary.

Oklahoma State Medical Association, Tulsa, Mayo Hotel, May 14-16. Mr. R. H. Graham, 210 Plaza Court Bldg., Oklahoma City, Executive Secretary.

Rhode Island Medical Society, Providence, May 14-15. Dr. Morgan Cutts, 106 Francis St., Providence 3, Secretary.

Society of American Bacteriologists, Philadelphia, May 13-16. Dr. Leland W. Parr, 1333 H St. N. W., Washington 5, D. C., Secretary.

South Dakota State Medical Association, Rapid City, May 31-June 3. Dr. Roland G. Mayer, 22½ S. Main St., Aberdeen, Secretary.

Texas, State Medical Association of, Dallas, Adolphus Hotel, May 5-8. Dr. Holman Taylor, 1404 W. El Paso St., Fort Worth 3, Secretary.

United States-Mexico Border Public Health Association, San Diego, California, and Tijuana, Mexico, May 6-8. Dr. James A. Grider Jr., 151 U. S. Court House, El Paso, Texas, Secretary.

West Virginia Medical Association, Charleston, May 12-14. Mr. Charles Lively, 1031 Quarrier St., Charleston 24, Secretary.

133
947

GOVERNMENT SERVICES

ARMY

ARMY AWARDS AND COMMENDATIONS

Colonel John Hargreaves

Col. John Hargreaves, M. C., U. S. Army, has been awarded the Bronze Star Medal and the Legion of Merit for meritorious achievement in connection with military operations against the enemy on Okinawa from Aug. 24, 1945 to Jan. 9, 1946. As surgeon, Eighth Air Force, he exhibited superior professional competence and sound judgment in solving numerous complex problems incident to the organization and direction of an effective medical service for that command. He inaugurated and supervised efficient field sanitary measures which resulted in an extremely low disease incidence rate despite adverse living conditions. Through his ability, resourcefulness and devotion to duty Colonel Hargreaves made a vital contribution to the success of the mission of the Eighth Air Force.

Selected also for citation were his services from July 1942 to July 1945 as surgeon Air Service Command and surgeon Air Technical Service Command. He directed most successfully the Industrial Medical Program and specialized training and classification of medical officer personnel for the Air Forces. His professional knowledge, presight and energetic effort contributed immeasurably to the success of this difficult program. Dr. Hargreaves graduated from the University of Minnesota Medical School in 1924 and entered the military service in 1924.

Lieutenant Colonel Francis E. McDonough

The Legion of Merit has been awarded to Lieut. Col. Francis E. McDonough, M. C., A. U. S., of Boston, who was cited for exceptionally meritorious conduct in the performance of services from Jan. 1, 1944 to Aug. 15, 1945. As assistant air surgeon of the XX Bomber Command, he ably and loyally supported the surgeon in guarding and maintaining the health of Bomber Command personnel in India and China, a task complicated by dispersal of bases over thousands of miles of territory with varying climatic and endemic disease problems. Lieutenant Colonel McDonough spent long hours at unusually hard work finding solutions to these problems. As wing surgeon of the 58th Bombardment Wing he planned the entire medical program for more than 10,000 officers and enlisted men. On arrival at Tinian he designed and followed through on the construction of a consolidated wing dispensary. His thorough knowledge of internal medicine, his appreciation of the flight surgeon's problems, his cooperative attitude and his unusual fidelity have made his services during the entire period of outstanding value. Dr. McDonough graduated from the University of Wisconsin Medical School in 1934 and entered the military service July 7, 1942.

Colonel John M. Murray

The Legion of Merit has been awarded to Col. John M. Murray (then Lieut. Col.), M. C., A. U. S., of Boston, the citation reading "As chief of the psychiatric branch, Office of the Air Surgeon, during the period from January 1943 to October 1944, Colonel Murray displayed extraordinary foresight and professional skill in successfully completing the organization of psychiatric service of the Army Air Forces. His outstanding achievement in the establishment of schools for the indoctrination of medical officers in modern psychiatric methods reflects great credit on himself and on the military service." Dr. Murray graduated from the University of Pennsylvania Medical School in 1921 and entered the military service, Nov. 1, 1942.

Lieutenant Colonel Willard H. Waterous

The Legion of Merit has been awarded to Lieut. Col. Willard H. Waterous, M. C., A. U. S., of Manila, P. I., for his services as chief of the eye, ear, nose and throat service at General Hospital Number 2, Bataan, Philippine Islands, from December 1941 to May 1942. Despite the lack of medications and equipment, the citation recalls that he successfully performed many difficult operations, and throughout the final days of the defense of the Bataan Peninsula he continued to exercise his characteristic cheerfulness and optimistic demeanor to such a degree as to enhance the morale and well being of all with whom he came in contact. His conduct reflects credit on himself and on the military service.

Dr. Waterous has also been awarded the Bronze Star Medal and the Oakleaf Cluster in lieu of a second Bronze Star Medal. He was a prisoner of the Japanese from April 9, 1942 until released by the American forces Feb. 5, 1945. He graduated from Northwestern University Medical School in 1916 and entered the service Dec. 11, 1941. Since the war Dr. Waterous has conducted a medical clinic in Manila.

Lieutenant Colonel Howard D. Fabing

The Legion of Merit has been awarded to Lieut. Col. Howard D. Fabing (then Major), M. C., A. U. S., of Cincinnati, for exceptionally meritorious conduct in the performance of outstanding services as director of the School of Military Neuropsychiatry, 312th Station Hospital, European Theater of Operations, from Nov. 15, 1943 to June 30, 1944. The citation reads, in part, that Major Fabing supervised the various courses and did all the teaching of division medical officers at the school. Through his efforts the training film entitled "Combat Exhaustion" was produced. He standardized therapy for the treatment of front line neuropsychiatric casualties so that over half of the men suffering from this disturbance could be returned to duty within a week. Few of the men who attended the school had previous special training in psychiatry, but, employing the methodology taught by Major Fabing, they have been successful in treating psychiatric casualties in the combat zones. Dr. Fabing graduated from the University of Cincinnati College of Medicine in 1932 and entered the military service Dec. 30, 1942.

Major Nathan B. Friedman

The Army Commendation Ribbon has been awarded to Major Nathan B. Friedman (then captain), M. C., A. U. S., who served from July 31, 1942 to Jan. 23, 1946, and whose intelligence and application to duty says the citation, contributed in large measure to the professional success of the Army Institute of Pathology, especially as it concerned diseases of the genitourinary tract and of the endocrine glands. His studies and research have contributed materially to medical knowledge, particularly of tumors of the testis and to the pathology of injuries resulting from cold and immersion, all conditions of great importance to the military service. Dr. Friedman graduated from Cornell University Medical College, New York, in 1934 and entered the military service July 30, 1942.

Captain Morris A. Shapiro

The Silver Star and the Oak Leaf Cluster to the Silver Star were awarded to Capt. Morris Shapiro, M. C., A. U. S., of Schenectady, N. Y., for gallantry in action in the vicinity of El Guettar, Tunisia, March 23, 1943. One notes from the citation that, when a medical detachment had been immobilized by enemy artillery fire, Captain Shapiro organized a group of soldiers as litter bearers and throughout several hours of concentrated enemy artillery fire directed the successful evacuation of the wounded.

His gallantry in action in the vicinity of St. Cloud, Algeria, Nov. 9, 1942, is also cited. When all other attempts had failed, Captain Shapiro, at grave risk to his own life, crept forward beyond our front lines and evacuated a seriously wounded officer who was lying exposed to constant enemy shell and small arms fire. His exemplary conduct inspired the members of his battalion. Dr. Shapiro graduated from Albany Medical College in 1936 and entered the service Feb. 17, 1941.

V 1
194

VETERANS ADMINISTRATION

LONG RANGE MEDICAL RESEARCH PROGRAM

Out of a conference called in April 1946 by the National Research Council at the suggestion of the Surgeon General of the Army is developing a long range program of medical research to improve the medical care of veterans. Some of the nation's foremost medical groups, the Army, Navy and Public Health Service are cooperating in this program. The conference stressed that the wealth of medical information accumulated by the armed forces during the war could be the starting point for clinical studies from which would come the best possible medical care for veterans in the years ahead. Then a committee of the National Research Council (Dr. Edward D. Churchill, chairman) outlined a broad program, and the chairman, Division of Medical Sciences, National Research Council (Dr. Lewis H. Weed), appointed a committee to handle details of the research program. As it develops the program is expected to include (1) follow-up studies to further knowledge of the natural history of diseases and the results of treatment, (2) clinical studies to be carried out in VA hospitals and other institutions and (3) statistical studies on mortality, morbidity and continued disability. Physicians of the Army, Navy and Veterans Administration desiring to submit proposals for research projects may do so on special forms provided for those agencies. All others may obtain forms from the office of the committee on Veterans Medical Programs, 2101 Constitution Avenue, Washington, D. C. The following doctors are on the committee:

O. H. Perry Pepper, Philadelphia.
Francis J. Braceland Rochester, Minn.
Edward D. Churchill, Boston.
Winchell McK. Craig Minneapolis.
Michael E. DeBakey, New Orleans.
Louis I. Dublin, New York.
Morris Fishbein, Chicago.
Perrin H. Long, Baltimore.
William C. Menninger, Topeka, Kan.
J. Roscoe Miller, Chicago.
Hugh J. Morgan, Nashville, Tenn.
Cornelius P. Rhoads, New York.
Milton C. Winternitz, New Haven, Conn.

ADVANCED TRAINING FOR NURSES

The Veterans Administration is conducting advanced courses in neurologic, psychiatric and tuberculosis nursing. Classes in neurologic nursing held at the VA hospital in Hines, Ill., for three months ended March 16 placed special emphasis on the care of paraplegic patients. The course, to be repeated in April, carries credit points of ten semester hours from DePaul University, Chicago. The course in advanced psychiatric nursing at the University of Minnesota, Minneapolis, which ended April 3, carries fifteen college credit hours. This course is being repeated beginning March 29. Advanced instruction in the care of tuberculous patients is being held at the VA hospital in Oteen, N. C. Classes, which began February 1, will extend through May 1. A course to teach VA nurses methods of training neuropsychiatric attendants was held in January at Cushing General Hospital, Framingham, Mass. A total of 113 nurses so far have attended the courses.

NEW HOSPITAL MANAGERS

Dr. Frank C. Cassidy, manager of the Veterans Administration hospital, Outwood, Ky., was appointed manager of the VA hospital, Memphis, Tenn., effective March 23. Dr. Raymond E. Scott, San Antonio, Texas, will succeed Dr. Cassidy at Outwood, Ky. Dr. Scott, a veteran of both world wars, during World War II was chief of laboratory service at Fort Bliss, Texas, and later served in this country and in Africa and Europe as inspector and instructor in army hospitals and as commanding officer of the 11th Evacuation Hospital. Dr. Cassidy, a graduate of Tufts College Medical School, has been in service in veterans' hospitals for many years.

Dr. Paul C. Bruce, a veteran of both world wars, is now manager of the VA hospital, San Fernando, Calif., succeeding the late Dr. Samuel H. James. Dr. Bruce formerly was manager of the VA hospital at Legion, Texas.

PUBLIC HEALTH SERVICE

HEADQUARTERS MOVED TO SOCIAL SECURITY BUILDING

The headquarters for the U. S. Public Health Service, formerly 1901 Constitution Avenue N.W., is now in the Social Security Building, Fourth Street and Independence Avenue S.W., Washington, D. C. The Public Health Service units now located in the Social Security Building are those which are part of the Office of the Surgeon General. They are the division of commissioned officers, the dental division, the sanitary engineering division, the division of nursing and the division of public health methods. Also included are the office of international health relations, the budget and fiscal office and employment office and office of the chief clerk in the office of the executive assistant.

The Public Health Service building on Constitution Avenue will be occupied by the Atomic Energy Commission. The Public Health Service headquarters have been in this building since 1933 with the exception of a period during the war when it was occupied by the joint chiefs of staff and the combined chiefs of staff.

OFFICERS RELEASED FROM SERVICE

U. S. Public Health Service headquarters reports that the following medical officers have been terminated, inactivated or retired and directed to proceed to the city opposite their name:

Buck, Irvin F., assistant dental surgeon (R), Saint Cloud, Florida.

Casey, Harry E., engineer (R), Whitehouse, Ohio.

Hinson, Harry L., J. A. sanitarian (R), Charlotte, N. C.

Kaniss, Harry A., S. A. dental surgeon (R), Reading, Pa.

Lentz, Phyllis S., J. A. nurse officer (R), Mobridge, S. D.

HEALTH EDUCATION

Dr. Mayhew Derryberry, chief U. S. Public Health Service's office of health education, has been assigned temporarily as consultant in health education with the American National Red Cross. Dr. Derryberry, at the request of the Red Cross, will study its present health education services for the purpose of evaluating and coordinating programs now in operation and will advise with Dr. G. Foard McGinnes, Red Cross vice chairman for health services, on possible future health education activities of the national organization.

MEDICAL RESEARCH GRANTS

The National Advisory Health Council has recommended medical research grants amounting to more than $2,000,000. These grants must first be approved by the Surgeon General, Dr. Thomas Parran, and then are contingent on appropriations by Congress for the fiscal year which begins July 1. Of the 193 grants that supplement existing funds of universities and other research institutions, the largest, $105,800, was recommended for a study of syphilis by the Pan American Sanitary Bureau. Sums of $52,454 and $46,000 respectively were slated for the study of malaria by the University of Chicago and Christ Hospital, Cincinnati. Six other grants were above $30,000. An additional 55 grants were favorably considered but await modification of the amount or further study by the research grants division of the National Institute of Health before final action is taken. The research study involved in these grants covers a diverse number of subjects. The use of grants in aid in pursuing these studies implies no degree of federal control. The National Advisory Health Council which recommends research grants consists of fourteen members ten of whom are experts not otherwise employed by the government (THE JOURNAL, March 15, p. 790).

PHYSICIANS SEPARATED FROM SERVICE

ARMY MEDICAL CORPS OFFICERS RECOMMENDED FOR/OR RELIEVED FROM ACTIVE DUTY

California

Cole, Harold A.....Los Angeles
Copeland, Joseph.....Visalia
Courtright, Lazarre J.....San Francisco
Fenmore, Milton S.....Ventura
Gordon, Kenneth W.....Los Angeles
Hill, Thomas P.....Lakeport
Kilroy, Dan O.....Sacramento
McCallum, Mac W.....Los Angeles
Markus, Ervin H.....San Francisco
Miller, Arthur W.....Riverside
Murray, Saunders.....Los Angeles
Nies, Arthur J.....Orange
Porter, Robert T.....Menlo Park
Reynolds, Frederick G.....Los Angeles
Rhone, Thomas B.....Orange
Rossiter, Stanford B.....San Francisco
Schatz, Milton M.....Fresno
Schneider, Paul J.....Berkeley
Snyder, William H. Jr.....N. Hollywood
Specker, Lewis.....Sacramento
Stewart, Charles M.....Los Angeles
Sweet, Ralph L.....San Francisco
Tompkins, Harold P.....Riverside
Trelstad, Bertram L.....Redding

Georgia

Williams, Virgil B.....Savannah

Illinois

Bennett, David.....Chicago
Bower, Robert D.....Bement
Byers, James C. Jr.....Granite City
Fairall, Emmett R.....Hines
Garthe, John J.....Rockford
Horkavy, John.....Chicago
Jansey, Felix.....Riverside
Latta, Philip R.....Leland
Lusk, Frank B.....Chicago
Lynch, James I.....Peru
McCue, Daniel J.....Hines
McMillan, Foster L.....Chicago
Madden, Thomas J.....Aurora
Matheson, Earl W.....Neponset
Mercer, Thomas H.....Oak Park
Miller, Edwin M.....Chicago
Moses, Jerome J.....Chicago
Mullen, Joseph J.....Glencoe
Nelson, Tell.....Chicago
Nicoll, Homer K.....Oak Park
Novack, Louis.....Chicago
Peck, Hyman.....Chicago
Purcell, James W.....Chicago
Quenzer, Fred A.....Maywood
Romano, John E.....Chicago
Temple, Claude O.....Chicago
Toomajan, Harry J.....Grayslake
Vander Lann, John E.....Chicago
Van Wien, Stefan.....Chicago

New Jersey

Allen, Samuel L.....Roselle
Beakes, Charles H. C. III.....Hackensack
Bekampis, Eugene H.....Merchantville
Belott, August V.....W. Orange
Copleman, Benjamin.....Perth Amboy
Costa, George J.....Jersey City
DeFilippis, Ralph L.....Newark
Edwards, Charles H. Jr.....Marlton
Feinberg, Harry.....Bayonne
LaPilusa, Salvatore J.....Bayonne
Levine, George I.....Jersey City
Levinson, Robert M.....Newark
Newman, Julius.....So. Orange
Opper, Philip.....Paterson
Piltz, George F.....Guttenberg
Pizzi, Mario V.....Orange
Revere, Seth D.....E. Orange
Roylance, Frank D. Jr.....Haworth
Smuda, Alphonse C.....Glendora
Somers, Willard H. Jr.....Englewood

New Jersey—Continued

Spirito, Michael W.....Elizabeth
Tickner, Louis.....Maple Shade
Tomlins, Francis I.....Ridgewood
Voss, Jack L.....Bernardsville
Wallen, Benjamin B.....Wildwood

New York

Beckenstein, Harry A.....Brooklyn
Becker, Clarence R.....Troy
Bender, Benjamin.....Brooklyn
Benschine, Frederick W.....Brooklyn
Birnbaum, David.....New York
Cole, Robert F.....Ossining
Copsey, Harvey G.....Rochester
Costabile, Richard J.....New York
Craig, Stanley H.....Brooklyn
DeLuccia, Victor C.....New York
DiFabio, Anthony J.....Bronx
DuBovsky, Mortimer H.....New York
Ehrlich, David E.....Brooklyn
Faraci, Charles J.....New York
Fragala, Frank J.....White Plains
Friedlander, Ralph.....New York
Friedman, George A.....New York
Gorson, Burton L.....Brooklyn
Kimaid, Emile.....Buffalo
McEvoy, Joseph J.....Richmond Hill
McHugh, Hugh.....New Rochelle
McKenna, Walter D.....Troy
McTamaney, Robert A.....Newburgh
Mellow, Joseph A.....Brooklyn
Messina, Philip V.....Brooklyn
Migden, Jacob I.....Brooklyn
Millemann, Raymond J.....Long Island
Miller, Saul.....Long Island
Montemarano, Vincent T.....Brooklyn
Morton, Edward A.....New York
Moskowitz, Morris.....Jackson Heights
Naidich, Harry.....Freeport
Nannariello, Joseph J.....White Plains
Nightingale, Arthur B.....Brooklyn
Obletz, Benjamin E.....Kenmore
Osroff, Sidney.....Brooklyn
Pashley, Warren J.....Cortland
Payne, Brittain F.....New York
Pier, Gardiner.....New York
Podryski, Vladimir.....Bronx
Porter, Charles H.....New York
Porter, Louis.....Forest Hills, L. I.
Pushkin, Aaron.....W. Hempstead
Re, Thomas V. B.....Brooklyn
Ripley, Herbert S. Jr.....New York
Ritter, Fred L.....Syracuse
Robbins, Jacques.....Middle Village
Rose, Sigmund P.....Brooklyn
Santoro, George R.....W. Brighton, S. I.
Schultz, Elack.....Bronx
Schwartz, Theodore B.....Forest Hills
Senne, Hubert S.....Glendale
Sieling, Walter H. Jr.....New York
Silvert, Meyer.....Bronx
Skorneck, Alan B.....New York
Smith, David J.....Brooklyn
Smith, Marion R.....Utica
Smith, Steward H.....New York
Smoleroff, Jules W.....Mt. Vernon
Snell, Philip.....New York
Sobel, Benno.....Chenango Forks
Solovay, Julius.....Brooklyn
Sommer, Murray M.....Bronx
Sposta, Dominick C.....New York
Steans, Maus W.....Schenectady
Steffenhagen, Dewey H.....Palatine Bridge
Steingold, Meyer.....Bronx
Stepler, Thea.....New York
Thygeson, Phillips.....New York
Toomey, Joseph H.....W. New Brighton
Townsend, Ralph P.....Hartsdale
Treitman, Arnold.....New York
Tytko, Michael J.....Schenectady

New York—Continued

Vandercar, Edward J.....Cohoes
Violyn, Roman R.....Amsterdam
Viti, Henry A.....Brooklyn
Weiner, Joshua H.....Brooklyn
Weinstein, Hyman W.....Brooklyn
Weiss, David.....New York
Yager, Irvin I.....New York

North Carolina

Matthews, William C.....Davidson
Mills, Charles R.....Greensboro
Moretz, William H.....Hickory
Morgan, William C.....Salisbury
Nowell, James S.....Franklinton
O'Brien, William A. III.....Leadsville

Texas

Beeler, George W.....Texas City
Bell, William E.....Houston
Belleggie, Philip A.....Houston
Bennack, George E.....Raymondville
Brandt, Otto Jr.....Brenham
Canales, Gregorio M.....Hebronville
Cleveland, Edwin M.....Dallas
Cole, Charles T.....Dallas
DeYoung, Richard.....Houston
Kilman, Joseph R.....Belton
Lowe, Thomas E.....Houston
Magers, Morris E.....Gainesville
Melton, Walter T.....Houston
Nixon, Pat I. Jr.....San Antonio
Oxford, Marvin B.....San Antonio
Polka, James B.....San Antonio
Ponton, Arvel R. Jr.....Fort Worth
Rimmer, Raymond J.....Dallas
Simpson, Neill O.....Waco
Warren, William S.....Center
Wilson, Reginald.....Liberty

Virginia

Bridgers, William H.....Newport News
Camp, James L. III.....Franklin
Fuller, John B.....Chester

Washington

Pettibone, Deane M.....Renton
Smith, Lloyd H.....Wenatchee
Whitaker, Clifford W.....Tacoma
Zimmerman, Wayne W.....Seattle

West Virginia

McCullough, Edison W.....St. Marys
Sloan, Robert D.....Clarksburg
Unger, Abraham.....Huntington

Wisconsin

Burdick, Harvey L.....Milton
Daniels, Farrington Jr.....Madison
Finn, Charles J.....Racine
Kreuter, George C.....Plymouth
Levin, Jules D.....Milwaukee
Pfeffer, Theodore J.....Racine
Pobanz, Samuel E.....Eau Claire
Rock, John W.....Milwaukee

Alaska

Weston, John I.....Seward

Hawaii

Chun, Lin T.....Honolulu

Puerto Rico

Morales, Luis A.....Naranjito
Palmer-Lopez, Arnaldo.....San Juan
Rivera-Aponte, Pedro.....Aguadilla
Torres-Oliver, Luis J.....San German
Vila, Jose L.....Yabucoa

Canal Zone

Springall, Arthur N.....Ancon

V 1
194

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST: SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION AND PUBLIC HEALTH.)

CALIFORNIA

Personal.—Dr. James J. Short, for many years associated with the New York Post-Graduate Medical School and Hospital, Columbia University, New York, is now on the faculty of the College of Medical Evangelists, Loma Linda-Los Angeles, as associate professor of medicine.——Dr. Leo Eloesser, San Francisco, for two years in charge of the medical teaching program for China under UNRRA, discussed his experiences in China before the Institute of Pacific Relations and the California League of Women Voters March 4.——Dr. C. S. Ambrose, Visalia, has been appointed health officer of Tulare County to succeed Dr. Charles C. Hedges.——Dr. Donald L. Meamber, recently returned from service in the Pacific theater with the Navy, has been appointed health officer of the city of Yreka.——Dr. Jacob M. Furstman, for twenty-four years chief administrative head of the Monrovia Health District, Monrovia, became health director of the Santa Monica District Health Office March 1, succeeding Dr. William F. Reasner, Santa Monica, who is retiring from county service.——Dr. Herbert L. Herschensohn, Santa Monica, has been appointed medical director for the Douglas Aircraft Company. Dr. Herschensohn, a graduate of New York University Medical School, is the author of a series of articles entitled "The Germs We Live With," published by *Hygeia*, the Health Magazine.

Changes in Licensure.—The Board of Medical Examiners meeting March 10 made the following changes in the status of licentiates: Frederick S. Lorenz, Beverly Hills, was found guilty of unprofessional conduct and his license was revoked. The order of revocation was suspended for five years, and he was placed on probation with specified terms for the period. The license of Dr. David A. Stevens, Lynwood, was revoked when he was found guilty of unprofessional conduct. Dr. Leonard D. Wood, Laguna Beach, was found guilty of unprofessional conduct; his license was suspended for one year and he was placed on probation for ten years without narcotics. The license of Dr. Jean Andrews was restored and the doctor was placed on probation for five years without narcotics. License was restored to Dr. Wendell W. White, Los Angeles, and he was placed on probation for a period of five years with specified terms.

Kern County Hospital Investigation.—A legislative subcommittee which has been investigating the administration of the county operated Kern General Hospital in Bakersfield has recommended the enactment of a law requiring such institutions to obtain licenses from the state department of public health. The subcommittee, headed by C. Don Field of Los Angeles County, filed a fifty-three page report charging the Kern County Hospital with employing unlicensed doctors, one of whom was accused of selling donated blood and retaining the proceeds. Chairman Field said a copy of the report is being forwarded to the attorney general for "proper action." "It is incredible and amazing," the report said, "that a situation such as that disclosed by the evidence at the subcommittee's hearings could have existed in Kern County; that a score of unlicensed doctors would be hired as county employees, with the knowledge of the board of supervisors and of the medical director of the county hospital and be permitted to practice medicine in flagrant violation of our law." The report noted that the Kern County district attorney has filed charges against Dr. Alfred E. Rhoden, Bakersfield, accused of practicing without a California license, and that the state board of medical examiners has suspended for one year the license of Dr. Nicolai N. Rilcoff, Bakersfield, former medical director of the hospital, after which he will be placed on probation for a period of five years (Sacramento, Calif., *Bee*, March 31, 1947).

COLORADO

Personal.—Dr. Horace J. Dodge, former director of public health at Coeur d'Alene, Idaho, has joined the faculty of the University of Colorado School of Medicine as assistant professor of public health and preventive medicine. After receiving his M.D. at the University of Colorado and taking his internship and residency at Colorado General Hospital, Dr. Dodge obtained his master's degree in public health at the University of Michigan.

Grant to Study Tick Fever.—Lederle Laboratories has renewed its grant of $2,400 to the University of Colorado School of Medicine, Denver, for continuing research on Colorado tick fever. Under the direction of Dr. Lloyd J. Florio, professor of public health and laboratory diagnosis, studies will be continued to try to determine how the disease is spread, whether it exists in other areas and whether the virus can be isolated in nature.

Hospital Classroom for Children.—A playroom and classroom for children undergoing treatment at Colorado General Hospital, Denver, have been built and furnished at the hospital in memory of a former Denver teacher, Lillian Drayton Matheson. The rooms were made possible by remodeling the south porch of the children's ward in the hospital. Attractively decorated and furnished for children, the classroom contains necessary schoolroom equipment, and the board of education supplies the services of a full time teacher.

University Medical Center.—Dr. Ward A. Darley Jr., dean, University of Colorado School of Medicine, Denver, has been named director of the University of Colorado Medical Center. The medical center is the new name approved by the University Board of Regents for the schools of medicine and nursing, Colorado General Hospital and the Colorado Psychopathic Hospital located in Denver. Dr. Darley's new title as director of the medical center entails no new duties, as he has been serving as the director of the schools and hospitals with the title as dean of the school of medicine, a position he will continue to hold.

CONNECTICUT

Studies of State Society Objectives.—Dr. Courtney C. Bishop, New Haven, was elected chairman and Dr. Frank H. Couch, Cromwell, secretary of the Committee to Study the Organization and Objectives of the State Medical Society at its recent meeting in New Haven. The committee, authorized by the House of Delegates last December, is composed of one council member and one additional delegate from each of the eight component county medical associations. It will meet once a month.

DISTRICT OF COLUMBIA

Appointments at Georgetown University.—Dr. Norman Q. Brill, assistant chief, neuropsychiatry, Veterans Administration, has been named professor of neurology and director of the department. Dr. Brill, a graduate of New York University College of Medicine, New York City, has served on the staffs of Montefiore Hospital for Chronic Diseases and Mount Sinai, Morrisania City, New York Postgraduate and Sydenham hospitals in New York City. He was also an instructor in neurology at Columbia University College of Physicians and Surgeons, New York City. He received his M.D. degree from Johns Hopkins University School of Medicine, Baltimore, in 1928. Dr. Willi Baensch, newly named professor of roentgenology, recently came to this country from the University of Leipzig. At the last meeting of the International Congress of Radiology in Chicago in 1937 he was elected secretary general of the organization. Dr. Samuel P. Hicks, a graduate of the University of Pennsylvania School of Medicine, Philadelphia, has been named associate professor of pathology. During the war he was in charge of the laboratory, base hospital No. 17, in New Guinea and has been assistant pathologist and head of the department of pathology, Naval Medical School, Naval Medical Center, Bethesda, Md. Dr. Robert F. Dow, Bethesda, Md., has been appointed head of the department of physical therapy. Dr. Dow in 1939 became director of the physical and fever therapy department at St. Joseph's Hospital, Paterson, N. J. Following military service he was appointed chief of physical medicine and physician-in-chief, medical rehabilitation, of the Veterans Administration Hospital, Washington, D. C.

ILLINOIS

Personal.—Dr. P. Kenneth Gieser, eye specialist, Wheaton, left last month for Kano, Nigeria, West Africa, to take charge of an eye hospital. Dr. Gieser graduated from Northwestern University Medical School, Chicago, and had additional training at the Illinois Eye and Ear Infirmary in Chicago.

Moorehead Memorial Fund.—A committee to plan a suitable memorial to the late Frederick B. Moorehead, D.D.S., M.D., former dean of the College of Dentistry, University of Illinois, Chicago, has been created by the Alumni Association of the college. The alumni and friends of Dr. Moorehead in the medical and dental professions are asked to send their checks to Robert I. Humphrey, D.D.S., Treasurer, Moorehead Memorial Committee, 185 North Wabash Avenue, Chicago.

Construct Plant to Eliminate River Pollution. — A recovery plant to eliminate all pollution in the Illinois River caused by the discharge of residues at the American Distilling Company's Pekin plant is being constructed and is expected to be in operation next summer. It will recover wastes equivalent to the average domestic wastes from a city of about 575,000 persons and is the final step in the pollution abatement program of the company cooperating with the state water board.

Physical Examination of School Children. — Illinois school children will be given physical examinations beginning Child Health Week, May 4-10, to be completed some time before the September opening of the schools, the Illinois State Medical Society announced April 6. The examinations are a part of the state law passed in June 1945 requiring, "as soon as practicable," that examinations be made of school children in all public, elementary and secondary schools at the time they enter first grade and again in not less than every fourth year thereafter. The exceptions are children whose parents object on religious scruples. Examinations will be made individually or in groups by appointment in the offices of physicians or in some communities at the schools.

Cook County Mosquitoes.—The Advisory Committee of the Chicago-Cook County Health Survey recommended an expanded attack on the mosquito population of Chicago and Cook County. The report was prepared by the United States Public Health Service as part of an audit of health conditions asked by city and county officials. The Des Plaines Valley and the North Shore Mosquito Abatement district, which began operation in 1928, are the only anti-mosquito agencies in the county. Using figures from a federal Works Progress Administration survey of the mosquito problem in 1940, the report disclosed that, of the estimated 66,698,000,000 mosquitoes in the county as a whole, 24 per cent, or 16,000,000,000 were produced in Chicago within Lake, Hyde Park and Calumet townships. If the seven southern townships within the county—Palos, Worth, Orland, Bremen, Thornton, Rich and Bloom—are added, "we find that 48 per cent of the breeding places within the county are within these ten southern townships and 49.6 per cent of mosquito production occurs therein." The report suggested enlargement of the Des Plaines Valley Abatement District to include the southern section and formation of new abatement districts in other parts of the county if necessary. The Des Plaines district has a permanent staff of ten, which is tripled during the mosquito season, and it annually spends about $45,000 on construction work, such as ditching, and on maintenance and control measures. The North Shore district has a similar staff. The most important two types of mosquitoes from the pest standpoint are Culex pipiens and Aedes vexans. The former breed in water collections near human habitations and are vicious biters both indoors and out. Aedes vexans rarely goes inside habitations and is particularly troublesome on porches, in yards and in recreational areas during the summer. It deposits eggs in dry depressions, and they hatch when the depressions become flooded. They resist winter temperatures and produce early spring broods. Two forms of Anopheles are found in the Cook County area but not in sufficient quantities to be of any great health hazards. The report adds, however, "it should always be borne in mind that, where Anopheles quadrimaculatus is prevalent and where persons infected with malaria come into the area there is always the possibility of a flare-up in that disease."

Chicago

The Bacon Lecture.—Hermann J. Muller, Ph.D., professor of zoology at Indiana University, will deliver the 1947 Charles Sumner Bacon lecture at the University of Illinois professional colleges, Wood and Polk streets, at 1 p. m. May 28 on "Human Erosion by Mutation." It is being sponsored by the department of obstetrics and gynecology.

The Joseph Capps Prize.—The Institute of Medicine of Chicago is again offering the Joseph Capps Prize of $400 for the most meritorious investigation in medicine or its specialties or in the fundamental sciences, provided the work has definite bearing on some medical problem. Competition is open to graduates of Chicago medical schools who completed their internship or one year of laboratory work in 1945 or thereafter. Manuscripts must be submitted to the secretary of the Institute of Medicine of Chicago, 86 East Randolph Street, Chicago 1, not later than December 31.

Northwestern University Medical Center.—Another step toward the $100,000,000 medical center now being established on the Chicago campus of Northwestern University Medical School was taken April 9 when Dr. J. Roscoe Miller, dean, announced receipt of the first of several gifts expected to total more than $5,000,000 for the creation of a fund to facilitate expanded research in the field of venereal diseases, other public health problems and medical education. The initial gift of $190,172, with others to follow in succeeding months, has been made from assets of the Public Health Institute of Chicago, founded in 1920 and supported by a large group of Chicago business men, which ceased operation early this year. Both the principal and the income from the half million dollar fund will be employed for research as well as for treatment and examination of patients in the clinic. Equipment and other physical property of the institute are to be turned over to the university to be used in connection with the fund. Erection of a neuropsychiatric hospital is assured through a bequest of a million and a half dollars from the late Mrs. Joy Morton. The Veterans Administration soon will build on the Chicago campus a 600 bed cancer hospital for the study and treatment of cancer. Mercy Hospital has purchased land adjacent to the campus on which it will erect a $10,000,000 hospital. Other hospitals, now located in various parts of Chicago, likewise are planning to move to or near the Chicago campus.

IOWA

Course in Audiometry.—The State University of Iowa will again offer an intensive four weeks course in audiometry and the fitting of hearing aids under the department of speech, psychology and otolaryngology from June 23 to July 19. A series of week end lectures and round table discussions on various aspects of hearing conservation will be part of the summer program. The speakers will be Mrs. Spencer Tracy, director of the John Tracy Clinic, Los Angeles; Dr. Helen Lane, principal, Central Institute for the Deaf, St. Louis; Dr. Werner Mueller, associate in otolaryngology, Massachusetts Eye and Ear Infirmary, Boston, and Harvard Medical School, and Martin F. Palmer, Sc.D., director, Institute of Logopedics, the Municipal University of Wichita, Kan. Inquiries may be addressed to Jacqueline Keaster, Assistant Professor, Speech and Otology, Speech Clinic, State University of Iowa, Iowa City.

KANSAS

Director of State Board Resigns.—Mr. Paul D. Haney, after fifteen years of service to the Kansas State Board of Health, has resigned the position of director and chief engineer of the division of sanitation, which he has held since 1942, to become an associate professor of sanitary engineering at the University of North Carolina, Chapel Hill. Mr. Ben L. Williamson, Des Moines, has accepted the appointment as director of the division of sanitation.

Establish a Cancer Registry.—The University of Kansas School of Medicine and Hospital, Lawrence-Kansas City, under the direction of the division of cancer control of the state board of health, is establishing a cancer registry. Abstracts of about 800 cases of cancer for the year 1945 from the records of the department of pathology have been completed. Cancer records from the William Newton Memorial Hospital and St. Mary's Hospital at Winfield have also been received. This is one of the initial steps leading to the establishment of diagnostic cancer clinics as approved by the cooperative cancer control group in Kansas, the Kansas Medical Society, the Kansas Division, American Cancer Society, and the Kansas State Board of Health.

LOUISIANA

University Appointments. — The Louisiana State University School of Medicine, New Orleans, announces the following faculty appointments: Dr. Jerome T. Syverton, formerly associate professor of bacteriology, University of Rochester School of Medicine and Dentistry, Rochester, N. Y., as professor and head of the newly formed department of microbiology; Dr. Curtis J. Lund, Madison, Wis., formerly associate professor of obstetrics and gynecology, University of Minnesota Medical School, Minneapolis, as professor of obstetrics and gynecology on a full time basis; Harold L. Brauer, instructor in pharmacology, Harvard Medical School, Boston, as assistant professor of pharmacology; Leon Churney, Ph.D., instructor in physiology, University of Pennsylvania, Philadelphia, as assistant professor of physiology; Dr. Allan L. Segal, instructor in radiology, Columbia University College of Physicians and Surgeons, New York, as clinical assistant professor of radiology; Dr. James A. Wilson, resident in obstetrics and gynecology, Charity Hospital, New Orleans, as full time instructor in obstetrics and gynecology; Dr. Harry D. L. Kaye, assistant in surgery, Yale University as full time instructor in surgery; Dr. Philip B. Johnson, New Orleans, recently

V 1
194

released from military service, as instructor in medicine. Other recent appointments include Dr. Juan E. Morales, New Orleans, as clinical assistant in neuropsychiatry; Dr. Marie L. Surgi, New Orleans, as assistant in pediatrics, and Dr. Robert M. Rose, Buffalo, as clinical assistant in orthopedics.

MAINE

Personal.—Dr. John G. Towne, Waterville, has resigned from the Maine Board of Registration of Medicine after eighteen years' service.——Dr. Roscoe L. Mitchell, Augusta, Maine state health director, has been elected vice president of the U. S. Association of State and Territorial Health Officers.

MASSACHUSETTS

Appoint Public Relations Executive.—The Massachusetts Medical Society has announced that a full time public relations executive will become a part of the organization July 1. Dr. John F. Conlin, Boston, a graduate of Tufts College Medical School, Boston, 1938, has been appointed director of medical information and education. After an internship at St. Elizabeth's Hospital, Boston, and a residency at Captain John Adams Hospital in Chelsea, he entered the army in 1942 and was discharged with the rank of colonel in 1946. He is now attending courses at the Harvard School of Public Health.

MICHIGAN

Personal.—Dr. Arthur G. Baker, Grand Rapids, has been appointed health officer of Allegan County. Dr. Baker, a graduate of the University of Michigan Medical School in 1943, formerly was assistant health officer in Calhoun County.

Short Practical Nursing Course.—St. Joseph Mercy Hospital, Pontiac, April 1 began enrolling women between the ages of 17 and 30 for a twelve month basic training session in nursing to prepare auxiliary personnel for the care of the sick. The course will include six weeks of basic training at St. Joseph Mercy Hospital in Detroit. At the end of a year certificates will be issued recognizing each trainee as a practical nurse.

MISSISSIPPI

Annual Meeting at Biloxi.—The annual meeting of the Louisiana-Mississippi Ophthalmological and Otolaryngological Society will be at Biloxi May 5. Drs. Samuel Fomon, New York City, will address the group on "The Rhinoplastic Operation and the Restoration of Nasal Function"; Peter C. Kronfeld, Chicago, "Newer Trends in the Treatment of Ocular Diseases," and Ralph Bowen, Houston, Texas, "Allergic Problems Seen by the Ophthalmologist and Otolaryngologist." The J. Raymond Hume Memorial Address will be delivered by Dr. Henry L. Williams, Rochester, Minn., on "Ménière's Disease."

MISSOURI

Dr. Moore Appointed Dean.—Dr. Robert A. Moore, who has been professor of pathology at Washington University School of Medicine, St. Louis, since 1939 and has served as acting dean of the school of medicine for the past year, has been appointed dean of the school. Dr. Moore is assistant secretary of the American Board of Pathology, editor of the *Journal of Gerontology* and during the war served as civilian resident consultant to the Army Medical Museum and to the Secretary of War on epidemic diseases and on committees of the National Research Council.

NEW JERSEY

New Diabetes Association.—The New Jersey Diabetes Association, affiliated with the American Diabetes Association, has been organized with Dr. Benjamin I. Saslow, Newark, chairman of the organizing committee. Disseminating knowledge of diabetes, educating the public, cooperating with associated groups and conducting clinical, experimental and demographic studies of diabetes are its aims. Interested physicians should contact Dr. Saslow at 102 Shanley Avenue, Newark 8.

Cooperative Mosquito Control.—Wallace T. Eakins of the state department of health, Trenton, in an address before the annual meeting of the New Jersey Mosquito Extermination Association April 4, reported that since the cooperative plan of malaria control went into effect in New Jersey in 1944 only 12 persons were known to have been infected by malaria within the state; however, 3,000 cases of imported malaria have been reported in New Jersey since 1944, mainly among returned service men.

Diphtheria Increased in 1946.—Reports received by the state department of health show that all but one of the twenty-one counties in the state reported cases of diphtheria in 1946, making a total of 120. The increase in cases over the previous year was 80 per cent. Counties reporting the largest number of cases were Camden, Hudson and Middlesex. The state department of health provides sixty distributing stations throughout the state where toxoid can be obtained by physicians free of charge.

NEW YORK

Four County Clinic Day.—Genesee, Livingston, Orleans and Wyoming County medical societies met April 9 in Rochester for an all day clinic program. Subjects discussed were "Gynecology in General Practice," "Plasma Therapy in Medicine, Surgery and Emergencies," "Tumors of the Gastrointestinal Tract" and "Diagnosis and Management of Rheumatic Fever." Dr. Konrad E. Birkhaug, Albany, New York State Department of Health, delivered the dinner address on "Immunization with BCG."

Personals.—Governor Dewey has appointed Dr. Frank A. Mastrianni of Mechanicsville coroner of Saratoga County to succeed the late Dr. Arthur W. Johnson. Dr. Mastrianni is president of the Saratoga County Medical Society and has been health officer of Mechanicsville for many years.——Dr. Ray E. Persons, Cairo, has been elected president of the Greene County Memorial Hospital staff to succeed Dr. T. Earl McQuade.——Dr. George Weber, Albany, has been appointed full time medical director of the Ulster County Tuberculosis Hospital at Kingston.

New York City

Personal.—At the 100th graduating exercises of Hahnemann Medical College and Hospital of Philadelphia, April 3, Dr. Samuel Weiss, New York, was awarded the degree of Doctor of Science.

Extend Children's Diagnostic Services.—An extension of the diagnostic service of the Children's Tumor Registry of Memorial Hospital was made early this year, with the establishment of the Children's Diagnostic Clinic. The service is offered to pediatric patients of hospitals and private physicians for the diagnosis of neoplastic disease and is available for ambulant or bed cases. The investigations will be performed at cost or without charge if the patient is unable to pay. On completion of the study the patient will be referred to the physician or institution interested, with a report of the findings. If therapeutic recommendations are indicated and requested, they will be made. Appointments may be made by mail or telephone.

OHIO

Annual State Medical Meeting.—The annual meeting of the Ohio State Medical Association will be held in Cleveland May 6-8 in the Public Auditorium and Hotel Cleveland under the presidency of Dr. Edgar P. McNamee, Cleveland. Speakers at the general sessions include:

Dr. Theodore L. Squier, Milwaukee, Hazard of Drug Hypersensitivity in Chemotherapy.
Dr. Philip Levine, Raritan, N. J., Clinical Importance of the Rh Factor.
Dr. John Q. Griffith Jr., Philadelphia, Rutin: Therapy for Capillary Abnormality in Hypertension.
Dr. Alan F. Guttmacher, Baltimore, Artificial Insemination: Indications and Technic.
Dr. Jerry C. Price, New York, Care of the Epileptic Person.
Dr. Zacharias Bercovitz, New York, Diagnosis and Treatment of Diarrheas and Dysenteries.
Dr. Andrew H. Dowdy, Rochester, N. Y., The Age of Atomic Power.

A new feature of the sessions are the instructional courses providing practical lectures and demonstrations on questions and problems arising most frequently in everyday practice. Cards for admission may be obtained in advance of the meeting on application to the Columbus Office, Ohio State Medical Association.

PENNSYLVANIA

Personal.—Dr. Ernest G. Williamson, Philadelphia, for many years resident surgeon at Presbyterian Hospital, has been appointed chief surgeon there. He is a graduate of Jefferson Medical College of Philadelphia and later completed postgraduate work at the University of Edinburgh, Scotland.

Philadelphia

Dr. Lahey to Lecture.—The first annual Phi Delta Epsilon lecture at the Hahnemann Medical College and Hospital of Philadelphia will be delivered by Dr. Frank H. Lahey, director, Lahey Clinic, Boston, May 12 on "Surgery of the Stomach, Duodenum and Jejunum."

133
947

RHODE ISLAND

Annual State Medical Meeting.—The Rhode Island Medical Society will hold its 136th annual meeting May 14-15 in the society's library at Providence under the presidency of Dr. Herman C. Pitts, Providence. The Charles V. Chapin Oration will be delivered by Dr. Stanhope Bayne-Jones, professor of bacteriology, Yale University School of Medicine, New Haven, on "Control of Typhus Fever." He will receive the Chapin Medal award from the city of Providence at the dinner meeting at the Narragansett Hotel. Among the speakers for the general program will be:

Dr. Malcolm J. Farrell, Waverly, Mass., Psychiatric Lessons Learned in the Army.
Dr. Chester S. Keefer, Boston, Antibiotic Agents in Clinical Medicine.
Dr. Elmer L. Sevringhaus, Nutley, N. J., Use of Estrogens and Progesterone.
Dr. William D. Wolfe, Baltimore, Common Dermatologic Conditions and Their Treatment.

WEST VIRGINIA

Rapid Treatment Center Transferred to State Department.—The Kanawha Valley Medical Center, the state's rapid treatment center, South Charleston, was transferred April 1 from the federal government to the state department of health. The present staff of forty-five, including two doctors, is being retained. During the three years the center was operated by the government 10,341 persons were treated. Of these, more than one fourth were under 21 years of age, 17.4 per cent between 18 and 21, and 1.3 per cent infants under 1 year of age. Other persons treated have ranged up to more than 60 years of age. The cost per patient for the treatment of syphilis has been about $46. After July 1 the state will probably assume about 30 per cent of the cost of the center.

Annual State Medical Meeting.—The eightieth annual meeting of the West Virginia Medical Association will be held at Charleston, May 12, under the presidency of Dr. Wade H. St. Clair of Bluefield. As usual, there will be no section meetings, but all the sections and affiliated societies will have representation on the program. Only the Tuesday night session will be held in the Daniel Boone Hotel. All other meetings, including both sessions of the house of delegates, will be held in the auditorium at the Shrine Mosque. Among the speakers at the scientific sessions will be:

Dr. Norman Treves, New York, Diagnosis and Treatment of Cancer of the Breast.
Dr. James G. Arnold, Baltimore, Prefrontal Lobotomy.
Dr. Emmerich von Haam, Columbus, Ohio, Clinical and Pathologic Concept of Hypersplenism.
Marjorie Shearon, Ph.D., Washington, D. C., Bureaucratic Control of Medicine.
Dr. James W. Bruce, Louisville, Ky., Infant Diarrhea.
Dr. Mark L. Gerstle Jr., New York, Psychiatry and the General Practitioner.
Dr. Joseph T. Beardwood, Philadelphia, The Modern Use of Insulin.
Dr. Walter C. Alvarez, Rochester, Minn., Puzzling Types of Abdominal Pain.
Dr. Arthur M. Master, New York, Diagnosis and Treatment of Acute Coronary Diseases.
Dr. Harrison H. Shoulders, Nashville, President, American Medical Association, Some Problems in the Economics of Medical Care.
Dr. R. Townley Paton, New York, Corneal Grafts.
Dr. John H. Foulger, Wilmington, Del., New Method of Studying Efficiency of the Heart and Circulation.
Dr. Louis H. Douglas, Baltimore, Abdominal Pregnancy.
Dr. Robert L. Bennett Jr., Warm Springs, Ga., Responsibility of the Physician in the Care of Acute and Convalescent Poliomyelitis.

Entertainment includes section and society luncheons, the past president's dinner Sunday night, a dance Tuesday night, a tea and reception at the executive mansion Wednesday afternoon, the annual banquet and ball Wednesday evening and the annual tennis and golf tournaments.

WISCONSIN

Appoint Professor of Physical Medicine.—Dr. Harry D. Bouman, formerly assistant professor of physical medicine, Northwestern University Medical School, Chicago, has been appointed associate professor of physical medicine at the University of Wisconsin Medical School, Madison. Dr. Bouman, a graduate of the University of Amsterdam, has held a Skostokvis Research Fellowship at the University of Paris and was a Rockefeller Foundation fellow in neurophysiology at University College, London. During the past six years his research has been directed toward the problem of infantile paralysis.

Psychologic and Psychiatric Aspects of Pediatric Practice.—An opportunity for study of the emotional, psychologic and psychiatric problems in pediatric practice is to be made available to those who are directing their work into these areas through the facilities of the University of Wisconsin Medical School, Madison, and the Wisconsin State Board of Health. This work will be given at the medical school and the State of Wisconsin General Hospital, Madison, from April 28 to May 18. Dr. Benjamin M. Spock, now associated with the Mayo Clinic, Rochester, Minn., as psychiatric consultant in pediatrics, and Dr. Milton J. E. Senn, associate professor of pediatric psychiatry, Cornell University Medical College, New York, will direct the work. Further details will be available through Dr. Llewellyn R. Cole, Coordinator of Graduate Medical Education, the Medical School, 418 North Randall Avenue, Madison 6, Wis.

HAWAII

Annual Medical Meeting.—The annual meeting of the Hawaii Territorial Medical Association will be held May 1-4 at the Lihue Parish House, Lihue, Kauai, under the presidency of Dr. Jay M. Kuhns, Lihue. Dr. Cyrus C. Sturgis of Ann Arbor, Mich., will speak on "Thirty Years' Experience with Coronary Artery Disease." Among other presentations will be:

Dr. Rogers L. Hill, Honolulu, Acute Appendicitis in Measles.
Dr. Tell Nelson, Honolulu, Management of the Allergic Patient.
Dr. Edward F. Slaten, Honolulu, Familial Erythroblastic Anemia.
Dr. Joseph E. Strode, Honolulu, Tumors Within or Adjacent to the Mediastinum.

GENERAL

Special Society Elections.—At a meeting of the Tri-State Medical Association in Greensboro, N. C., Dr. Charles N. Wyatt, Greenville, S. C., was made president-elect and Dr. S. Raymond Thompson, Charlotte, became president of the association.

Rockefeller Foundation Appropriations.—The Rockefeller Foundation, which made appropriations totaling $19,481,576 during 1946, gave $1,395,985 to aid in medical science. Of this amount $360,435 was made to psychiatry, neurology and allied sciences, $272,000 to endocrinology, $75,350 to medical education, $88,200 to group medicine and medical economics and $600,000 to fellowships and grants-in-aid.

Allergy Research Fund.—The American College of Allergists announces a grant of $1,500 from Luziers, Inc., Kansas City, Mo., for continuation of allergy research in the field of dermatology. This fund will be under the direction of Dr. Rudolph L. Baer, assistant attending physician, New York Skin and Cancer Hospital, New York, and Dr. Stephan Epstein, Marshfield Clinic, Marshfield, Wis.

The S. S. Frederick Banting.—At the request of a group of American physicians in 1943 the U. S. Maritime Commission named a liberty ship in honor of Sir Frederick Banting, the discoverer of insulin. In doing so the rule that all American ships must be named for citizens of this country was set aside. The ship was presented to the British commonwealth. Since Dec. 30, 1943, when the ship was delivered under lend lease, it has been operated by the British to ports in Japan, China, Australia, India, the Mediterranean and Canada.

Venereal Disease Pamphlets.—The U. S. Public Health Service has just issued three new publications to spur an effective educational program concerning venereal disease: "Facts About Syphilis and Gonorrhea," "Wedding Plans" and "Protecting the Unborn Baby." Sample copies are available free on request to U. S. Public Health Service, Washington 25, D. C., or quantity orders may be purchased from the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

Traffic Safety Awards.—Connecticut and Washington, D. C., have been named grand award winners in the 1946 National Traffic Safety Contest conducted by the National Safety Council. From the 1,355 cities participating in the contest, the annual special awards for sustained records in excellence in traffic safety for five or more consecutive years were given to Milwaukee and Beaver Dam, Wis.; Stillwater, Okla., and Coshocton, Ohio. Cities competing in the contest represented more than 90 per cent of the present population of the United States.

Clinical Research on New Drug.—Dr. William A. Nicholson, Duke Hospital, Durham, N. C., and Dr. Robert A. Goodwin, Vanderbilt University Hospital, Nashville, Tenn., have been awarded research grants by Sharp and Dohme, Inc., Philadelphia, it was announced February 19. Both grants are in support of clinical studies on the evaluation of caronamide, 4'carboxyphenylmethanesulfonamide, a new drug. Used in conjunction with penicillin, caronamide is said to inhibit the excretion of penicillin from the body and serves to maintain high therapeutic concentrations of the antibiotic in the blood for longer periods of time.

V 1
194

Birth Rate Increasing in United States.—According to the March issue of the United Nations Monthly Bulletin of Statistics, the United States birth rate is the highest in history. Decreasing steadily from 1915 to a low point in 1933, the rate in the United States rose from 17.1 births per thousand inhabitants in 1937 to an annual rate of 28.8 in November 1946. Of the twenty countries included in the tables, Uruguay, Chile and Belgium are static and India and Egypt show noticeable declines. Palestine showed the highest birth rate, 43.4. The trend of the birth rate in World War II differs from that in World War I. A drop occurred during World War I and a slight rise only after the Armistice, while in this decade a general rise has occurred through the war years.

Special Society Elections.—At a recent meeting the American College of Allergists elected Drs. Hal M. Davison, Atlanta, Ga., president-elect; George E. Rockwell, Milford, Ohio, and Willard S. Small Jr., Pasadena, Calif, vice presidents, and Frederick W. Wittich, Minneapolis, secretary-treasurer. Dr. Leon Unger, Chicago, was installed as president.——The Society of Physical Medicine has elected Drs. Earl C. Elkins, Rochester, Minn., president; Miland E. Knapp, Minneapolis, vice president; Milton G. Schmitt, Chicago, secretary-treasurer. Dr. William D. Paul, Iowa City, was installed as president.——The American Board of Pathology announces the election of Drs. Nathan C. Foot, New York, president; William Sunderman, Philadelphia, vice president, and Robert A. Moore, St. Louis, secretary-treasurer.——The Central New York Eye, Ear, Nose and Throat Society has elected Drs. Uri Doolittle president and Alfred W. Doust, both of Syracuse, secretary.

Records of Committee on Medical Research, OSRD.—In closing the office of the Committee on Medical Research of the Office of Scientific Research and Development, Washington, D. C., the records that accumulated during the war years 1941-1946 are being distributed to libraries throughout the country in order that they may be available to interested persons. Among the records so distributed are complete sets of the seventy-eight issues of the (1) weekly bulletin entitled "Summary of Reports Received by the Committee on Medical Research"; these bulletins contain abstracts of the "open" and "restricted" reports received from investigators; (2) bound and indexed sets of reprints of published work done under OSRD-CMR contracts; (3) indexed sets of the 734 numbered reports issued by the Board for the Coordination of Malarial Studies; (4) Aviation Medicine Reports: a complete set of the 505 numbered reports issued by the National Research Committee on Aviation Medicine; (5) final and interim reports of CMR investigators. Copies of almost all these reports are on file in the Office of Medical Records, National Research Council, 2101 Constitution Avenue, Washington, D. C., where they can be consulted but cannot be sent out on loan.

Danger in the Kitchen.—The Statistical Bulletin of the Metropolitan Life Insurance Company estimates from studies among Metropolitan industrial policyholders and among other groups that about 6,000 persons are killed annually in the United States from mishaps in the kitchen and that many times that number are injured more or less seriously, though not fatally. In no other room in the house does such a concentration of hazards exist. The most frequent type of fatal accident in the kitchen is burns and scalds. Falls, which rank second, are said to be responsible for about 1,500 deaths in kitchens annually. Among the hazards contributing to these falls are wet or waxed floors, worn linoleum or other floor coverings, unanchored small rugs, pails or other objects left on the floor; falls from tables, ladders, windows, chairs and highchairs. Gas poisoning is a relatively frequent cause of accidents in the kitchen, more particularly among men who doze off while heating coffee or other fluids which boil over and put out the gas flame. Trouble may arise from a defective pilot light which is out or is not functioning; gas jets may be turned on unknowingly by persons brushing against them; some people may turn on the gas and forget to light it. Other contributing conditions to such deaths are burning gas with an excessively high flame in a poorly ventilated kitchen, improperly installed heaters and gas appliances in poor repair. Fatalities in the kitchen are also caused not infrequently by such poison compounds as roach powders or rat poisoning carelessly kept and mistakenly used for flour or baking powder. The modern kitchen is a combination bakery, cannery, laundry, restaurant, factory and butcher shop and playground. In industry, where similar hazards exist, either state officials or trained employees help to control accidents, but in the home this responsibility usually falls on the woman of the house, who should know where the chief dangers lie.

CANADA

Personal.—Dr. Kenneth E. Dowd, Montreal, Que., chief medical officer of the Canadian National Railways and Trans-Canada Air Lines since 1943, has been elected chairman of the medical and surgical section of the Association of American Railroads. During the second world war he served as medical consultant in civil aviation to the Royal Canadian Air Forces and as chief medical consultant of the Royal Air Force Ferry Command.

LATIN AMERICA

Personal.—Dr. Guillermo Diaz, Lima, Peru, who recently visited the headquarters of the American Medical Association in Chicago, is head of the National Department of Sanitary Education in Peru. With a scholarship from the Institute of Inter-American Affairs he will do postgraduate work on public health and sanitation and visit American medical centers.

New Medical Journal.—*Archivos de Neuro-Psiquiatria*, the official organ of the Sanatorio Dr. Galigarcia, which recently appeared, is a quarterly journal with editorial headquarters in Havana, Cuba. The second issue, September 1946, contains sections of editorials, medical news, original articles and abstracts of articles. Some of the articles are translated from English or Portuguese medical journals.

FOREIGN

Great Britain

Plans for National Health Services.—The National Health Service Act will probably come into operation on April 1, 1948. Mr. Aneurin Bevan, minister of health, recently made this announcement to the local health authorities, according to British Information Services, when he asked them to start reorganizing the home and health services for which they will be responsible under the act—services which will provide free health care to all residents of Britain regardless of their financial status. Mr. Bevan gave the following time table for submitting proposals concerning the reorganization of the various services:

Vaccination and immunization Ambulance services	June 30, 1947
Midwifery Health nursing Prevention of illness, care and after care Domestic help Duties under lunacy and Mental treatment act and Mental deficiency acts	August 31, 1947
Care of mother and young children	September 30, 1947
Health centers	November 30, 1947

The aim is to frame plans which will provide as efficient and comprehensive a service as prevailing conditions permit. The membership of the health committee of each local health authority must be considered. The act provides that while a majority of the health committee must be members of the parent authority, outside persons may also be appointed, thus allowing the inclusion of doctors and other experts. Mr. Bevan has also suggested that, in view of the nature of the services with which the committee will be concerned, its membership should include an adequate proportion of women. Preliminary proposals about the provision of health centers will cover the reservation of suitable sites for such centers.

Marriages

PAUL A. MEREDITH, Caro, Mich., to Miss L. Virginia Hunter of Howard, Kan., in Chicago Nov. 22, 1946.

NORMAN BALFOUR KANOF, Richmond, Va., to Miss Joan Winifred Sher of Brooklyn Dec. 15, 1946.

CHARLES HYATT PLACE, Poundridge, N. Y., to Miss Ruth Evelyn Murray of Brooklyn January 18.

WILFRED S. MILLER, Assumption, Ill., to Mrs. Felice Connolly of Taylorville in Kewanee Nov. 25, 1946.

DAVID MARCUS, Astoria, N. Y., to Miss Shirley Lenore Edelstein of Rego Park recently.

MAX BENJAMIN MILBERG, Brooklyn, to Miss Lillian Gertrude Kling of New York March 9.

WILLIAM I. POOLE, Calvert City, Ky., to Mrs. Verda Lawson of Paducah Dec. 10, 1946.

SAMUEL MYERSON to Miss Phyllis Greenhill, both of New York, March 16.

Deaths

Martin Aaron Bernfield ✠ San Antonio, Texas; born in Jaffa, Palestine, July 19, 1892; University of Michigan Medical School, Ann Arbor, 1929; interned at the City of Detroit Receiving Hospital; during World War I served as an intelligence officer in the Russian army; later joined the British army and served in the Upper Sudan campaign in 1919; at the outbreak of World War II was commissioned passed assistant surgeon in the U. S. Public Health Service with the rank of captain; at the time of his death was associated with the San Antonio regional office of the Veterans Administration as medical officer full grade, neuropsychiatric examiner; died Aug. 22, 1946, aged 54, of coronary thrombosis and embolus of the abdominal aorta.

Ira Price Burdine Jr. ✠ Amory, Miss.; Tulane University of Louisiana School of Medicine, New Orleans, 1931; interned at the Charity Hospital in New Orleans and the Mississippi State Charity Hospital in Jackson; served a residency at the Mississippi State Tuberculosis Sanatorium in Sanatorium; began active duty as a captain in the medical corps, Army of the United States, on Sept. 29, 1942; promoted to major; released from service Aug. 27, 1946; died in the (Kennedy) Veterans Administration Hospital, Memphis, Tenn., Oct. 29, 1946, aged 40, of acute gastritis and congestion of the lungs.

James Darrah Osborn ✠ Frederick, Okla.; born Dec. 23, 1879; Medical Department of Tulane University of Louisiana, New Orleans, 1901; served as secretary of the Oklahoma State Board of Medical Examiners and Board of Examiners in the Basic Sciences; president of the Oklahoma State Medical Association; member of the National Board of Medical Examiners; president-elect of the Federation of State Medical Boards; formerly superintendent of public health; killed February 7, aged 67, when a St. Louis bound Frisco passenger train was derailed at Republic, Mo.

Isaac Rosenbaum Pels ✠ Baltimore; born in Baltimore, Oct. 8, 1881; Johns Hopkins University School of Medicine, Baltimore, 1906; assistant professor of dermatology at his alma mater; specialist certified by the American Board of Dermatology and Syphilology; member of the American Dermatological Association and the American Academy of Dermatology and Syphilology; on the staffs of the Johns Hopkins, Bon Secours, Sinai, Union Memorial and Baltimore City hospitals and the Church Home and Infirmary; died February 4, aged 65, of cardiovascular disease.

James Cox Archer ✠ Senior Surgeon, U. S. Public Health Service, Fort Stanton, N. M.; Baylor University College of Medicine, Dallas, 1933; entered the U. S. Public Health Service in 1934; in charge of the U. S. Marine Hospital, where he died February 1, aged 43, of coronary occlusion.

Peter C. Berns, Linton, Ind.; Missouri Medical College, St. Louis, 1897; member of the American Medical Association; served with the British army during World War I; died January 16, aged 74.

Marshall Merrill Best, Honolulu, Hawaii; University of Cincinnati College of Medicine, 1927; member of the American Medical Association and the Ohio State Medical Association; awarded the Bronze Star medal for meritorious service during World War II; died January 3, aged 46.

Zelly Adam Bonoff, New Haven, Conn.; Yale University School of Medicine, New Haven, 1904; died in the New Haven Hospital January 30, aged 66, of arteriosclerotic heart disease.

Andrew Jackson Brown, Clarksdale, Miss.; Chicago College of Medicine and Surgery, 1909; member of the American Medical Association; at one time member of the state board of medical examiners; formerly superintendent of the State Charity Hospital in Natchez; died January 30, aged 71, of carcinoma of the liver.

John Thomas Brown, Forrest City, Ark.; Memphis (Tenn.) Hospital Medical College, 1885; died in a hospital at Memphis, Tenn., January 22, aged 84, of a hip fracture received in a fall.

Joseph R. Burdett, Tennille, Ga.; Bellevue Hospital Medical College, New York, 1889; member of the American Medical Association; died Dec. 9, 1946, aged 84.

Lilburn Ira Burrows, Batesburg, S. C.; Baylor University College of Medicine, Dallas, Texas, 1932; interned at St. Anthony Hospital in Oklahoma City; formerly a medical missionary in India; served during World War II; died in the Veterans Administration Hospital, Columbia, February 27, aged 45, of cirrhosis of the liver.

George Hull Camp, Springfield, Mo.; Emory University School of Medicine, Atlanta, 1920; member of the American Medical Association; served during World War I and II; affiliated with St. John's Hospital, where he died January 29, aged 53, of uremia.

Bernard McHugh Cline ✠ Atlanta, Ga.; Atlanta College of Physicians and Surgeons, 1905; affiliated with St. Joseph Infirmary, Georgia Baptist Hospital and the Crawford W. Long Memorial Hospital; died January 26, aged 65, of coronary thrombosis.

Allan Loeb Cohn, Shreveport, La.; University of Wisconsin Medical School, Madison, 1937; member of the American Medical Association; for many years a member of the Caddo-Shreveport health unit; died January 22, aged 35.

William Corns, Tama, Iowa; Drake University Medical Department, Des Moines, 1900; member of the American Medical Association; served during World War I; formerly on the staff of the Iowa Soldiers' Home at Marshalltown; died January 26, aged 73, of carcinoma of the stomach.

Anna Elizabeth Mulheron Coyle, Windsor Locks, Conn.; Woman's Medical College of Pennsylvania, Philadelphia, 1912; member of the American Medical Association; school physician and assistant health officer; died January 27, aged 62, of coronary thrombosis.

William Hartwell Cressy, Brooklyn; Chicago College of Medicine and Surgery, 1909; Medical Department of Tulane University of Louisiana, New Orleans, 1914; medical officer in the Serbian army during World War I; died in the Methodist Hospital January 12, aged 67.

Alden Larue Crittenden ✠ Wichita, Kan.; Rush Medical College, Chicago, 1912; fellow of the American College of Surgeons; on the staff of the Wesley Hospital; died January 20, aged 63, of leukemia.

William Donovan, New York; Bellevue Hospital Medical College, New York, 1898; member of the American Medical Association; died in the Lenox Hill Hospital January 30, aged 78.

Alice Barker-Ellsworth, Long Beach, Calif.; University of Michigan Department of Medicine and Surgery, Ann Arbor, 1902; member of the American Medical Association; a medical officer in the army during World War I; served on the Los Angeles County Child Welfare Board; past president of the Women's Medical Association of Los Angeles County; died January 7, aged 70, of cerebral hemorrhage.

Fred Leslie Ervay, Fredonia, Kan.; Keokuk Medical College, College of Physicians and Surgeons, 1908; also a dentist; for many years member of the board of education; died January 22, aged 66, of carcinoma of the bladder.

John O'Fallon Farrar, St. Louis; Barnes Medical College, St. Louis, 1896; died January 25, aged 79, of carcinoma of the liver.

Frank Crist Fisher, Bloomington, Ill.; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1903; member of the American Medical Association; on the staff of the Brokaw Hospital and member of the board of the Fairveiw Sanatorium, Normal; an examiner on the U. S. Exemption Board of Bloomington during World War I; died January 24, aged 78, of coronary thrombosis.

Cornelius A. Fossum, Joplin, Mo.; Loyola University School of Medicine, Chicago, 1919; died Dec. 17, 1946, aged 56.

Johanna Gelien, Berkeley, Calif.; Denver and Gross College of Medicine, 1908; member of the American Medical Association and the Colorado State Medical Society; died January 28, aged 78, of coronary occlusion.

John Relda Gideon, Joiner, Ark.; Mississippi Medical College, Meridian, 1912; Kansas City (Mo.) College of Medicine and Surgery, 1920; died January 9, aged 61.

Stowell Burrough Grant, Munnsville, N. Y.; Albany (N. Y.) Medical College, 1906; member of the American Medical Association; past president of Madison County Medical Society; school physician; on the staff of the Oneida City (N. Y.) Hospital; died in Oneida January 23, aged 65, of coronary thrombosis.

Charles William Hamilton, Hood River, Ore.; University of Oregon Medical School, Portland, 1914; city health officer; on the staff of the Hood River Hospital; died in Coos Bay recently, aged 60, of carcinoma of the head of the pancreas.

Charles Merrill Hazard ✠ Arlington, Iowa; State University of Iowa College of Homeopathic Medicine, Iowa City, 1910; served during World War I; died January 30, aged 61, of cerebral hemorrhage.

James Henry Hill, Talladega, Ala.; Birmingham Medical College, 1909; member of the American Medical Association; served as secretary of the Talladega County Medical Society; county health officer; died January 19, aged 66, of right ventricular failure and renal disease.

Charles Edwin Hood. Ann Arbor, Mich.; Detroit College of Medicine, 1898; at one time health officer of Drayton, N. D.; died in the University Hospital January 29, aged 80, of bronchopneumonia.

John Jones Jack, Stamps, Ark. (licensed in Arkansas in 1903); served as health officer; died January 12, aged 76.

Harry Jarmulowsky ✠ Paterson, N. J.; Christian-Albrechts-Universität Medizinische Fakultät, Kiel, Prussia, Germany, 1906; on the staffs of the Barnert, General and St. Joseph's hospitals; died January 27, aged 69, of hypertensive heart disease.

J. H. Johns, Westminster, S. C.; Atlanta Medical College, 1898; formerly state senator; died January 28, aged 72.

Grace Elizabeth Atkins Jordan, Boston; Boston University School of Medicine, 1899; died January 15, aged 74, of carcinoma of the kidney.

John McLean Karch, Cincinnati; Ohio State University College of Medicine, Columbus, 1929; member of the American Medical Association; began active duty as a captain in the medical corps, Army of the United States, Sept. 2, 1942; released from service Jan. 19, 1945; served an internship at the Good Samaritan Hospital, where he was on the staff; accidentally killed while hunting February 12, aged 47.

Thomas Junior Kemp, Clayton, Mo.; Columbian University Medical Department, Washington, D. C., 1900; past president of St. Louis County Medical Society; member of the American Medical Association; on the staffs of the Faith and Park Lane Memorial hospitals; died January 23, aged 72, of heart disease.

Frank Peter Knabb ✠ Valley Park, Mo.; Barnes Medical College, St. Louis, 1902; past president of St. Louis County Medical Society; president of the school board; died in the Missouri Baptist Hospital, St. Louis, January 29, aged 71, of uremia.

William Roscoe Koob, Brayton, Iowa; Ensworth Medical College, St. Joseph, 1892; member of the American Medical Association; died in Long Beach January 16, aged 77, of coronary occlusion.

Lorenz Kronrad, Columbia, S. C.; Medical College of the State of South Carolina, Charleston, 1935; member of the American Medical Association; served during World War II; died January 19, aged 35, of coronary occlusion.

Jean Baptiste LaBorde, Columbia, S. C.; Medical College of the State of South Carolina, Charleston, 1918; member of the American Medical Association; served during World War I, as chairman of the city board of health and as county physician; died January 3, aged 53.

Bernard Vincent Lally, Tiffin, Ohio; Eclectic Medical College, Cincinnati, 1937; member of the American Medical Association; served on the staffs of St. Mary's and Deaconess hospitals in Evansville, Ind.; director of health for Seneca County; died January 28, aged 40, of heart disease, following pneumonia.

Asher Noah Lebensohn, Washington, D. C.; Northwestern University Medical School, Chicago, 1938; interned at Los Angeles County Hospital; formerly on the staffs of the Veterans Administration facilities in San Fernando, Calif., and Wadsworth, Kan.; served during World War II; died Dec. 17, 1946, aged 33.

Clarence Wyman Lincoln, Wayne, Pa.; University of Pennsylvania Department of Medicine, Philadelphia, 1893; served during World War I; died in the Bryn Mawr (Pa.) Hospital January 22, aged 80, of uremia.

John Linder, Neponsit, N. Y.; University and Bellevue Hospital Medical College, New York, 1904; fellow of the American College of Surgeons; served as clinical professor of surgery at the Long Island College Hospital in Brooklyn, where in 1937 a plaque was presented to the Jewish Hospital in recognition of his service as a member of the medical staff; served on the staff of the Beth-El Hospital; died January 12, aged 64.

William H. Little, Alta Vista, Kan.; Kansas City (Mo.) Medical College, 1900; died in Phoenix, Ariz., January 21, aged 78, of cerebral hemorrhage and arteriosclerosis.

George Emory Lochner, Albany, N. Y.; Albany Medical College, 1889; member of the American Medical Association; formerly clinical professor of gynecology at his alma mater; chief of staff at the Brady Maternity Home since its establishment; on the staff of the Memorial Hospital; died January 29, aged 79, of jaundice and intestinal obstruction.

Thomas Dick Longino, Atlanta, Ga.; University of Georgia Medical Department, Augusta, 1870; Jefferson Medical College of Philadelphia, 1882; member of the American Medical Association; Civil War veteran; served on the city council, at various times mayor of Palmetto, mayor of West End when it was a separate corporation from Atlanta and as mayor pro tem of Atlanta; on the board of trustees of the Grady Hospital; died in St. Joseph's Infirmary January 28, aged 100, following prostatic resection.

John Roy McKnight ✠ Colonel, U. S. Army, retired, Bellwood, Pa.; Jefferson Medical College, Philadelphia, 1906; Army Medical School in 1911; entered the medical corps of the U. S. Army as a first lieutenant in March 1911; served during World wars I and II; rose through the various ranks; became colonel on March 19, 1937; retired April 5, 1945; died January 22, aged 66, of heart disease.

Burton Maltby ✠ Liberty, Mo.; University Medical College of Kansas City, 1908; served with the British army during World War I and was awarded the British Military Cross; served as county physician, county coroner, member and president of the school board; on the visiting staffs of the Research Hospital in Kansas City and the Excelsior Springs (Mo.) Hospital, where he died January 29, aged 61, of cerebral hemorrhage and carcinoma of the colon.

Charles Raysor May, Bennettsville, S. C.; Medical College of the State of South Carolina, Charleston, 1897; member of the American Medical Association; honorary member, past president and formerly councilor of the Sixth District of the South Carolina Medical Association; past vice president of the Tri-State Medical Association; on the staff of the Marlboro County General Hospital; died January 21, aged 74, of coronary thrombosis.

William Charles Meacham, Oak Park, Ill.; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1910; served overseas during World War I and received the Croix de Guerre and several other citations; physician for the Chicago Black Hawks hockey team and the Chicago Cardinals football team; died February 11, aged 60, of coronary occlusion.

Edward Frederick Meyer, Chicago; Jenner Medical College, Chicago, 1900; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1901; served on the staff of the Augustana Hospital; died in St. Mary of Nazareth Hospital January 26, aged 81, of arteriosclerosis.

Stafford T. Mitchell, Chicago; Hering Medical College, Chicago, 1895; died February 13, aged 82, of arteriosclerotic myocarditis.

John Claude Moore ✠ Seattle; Cooper Medical College, San Francisco, 1895; past president of the King County Medical Society; served on the staffs of the old Seattle City and King County hospitals, as trustee of the Doctors Hospital and one of the six doctors who reorganized Maynard Hospital; died February 16, aged 74, of heart disease.

Michael C. Mullen, Chicago; College of Physicians and Surgeons of Chicago, 1894; associate clinical professor of obstetrics and gynecology at the Loyola University School of Medicine; on the staff of the Mercy Hospital; died February 28, aged 76, of coronary thrombosis.

Charles M. Myers, Dowagiac, Mich.; the Hahnemann Medical College and Hospital, Chicago, 1895; served two terms as state representative; city health officer; for many years member of the board of education, serving as president; served on the library board; died in the Lee Memorial Hospital January 24, aged 82, of coronary occlusion.

Henry Hasswell Nadig, Errol, N. H.; Chicago Homeopathic Medical College, 1898; died in Rowayton, Conn., January 31, aged 70, of coronary thrombosis.

Theodore McGeachy Northrop ✠ Greenville, S. C.; Vanderbilt University School of Medicine, Nashville, Tenn., 1934; interned at the Greenville City Hospital; on the staffs of St. Francis and Greenville General hospitals; died January 11, aged 38, of uremia.

Frederick William Nueske, Bayshore, N. Y.; Long Island College of Medicine, Brooklyn, 1932; interned at the Nassau Hospital in Mineola; served during World War II; medical consultant for the department of public welfare of Suffolk County; associate staff member at South Side Hospital; died January 29, aged 39, of coronary occlusion.

Robert P. Oppenhimer, Knoxville, Tenn.; Medical College of Virginia, Richmond, 1891; member of the American Medical Association; served as a member of the city school board; died January 26, aged 78, of lobar pneumonia and arteriosclerosis.

Giovanni Paccione, New York; Regia Università degli Studi di Bologna. Facoltà di Medicina e Chirurgia, Italy, 1912; member of the American Medical Association; served during World War I; on the staff of the New York Eye and Ear Hospital; for many years on the staff of the Columbus Hospital; member of the welfare and health departments; died January 22, aged 60, of coronary thrombosis.

George Baldwin Palmer, Rolfe, Iowa; Chicago Homeopathic Medical College, 1899; died in St. Joseph Mercy Hospital, Fort Dodge, January 6, aged 75, of carcinoma of the pancreas.

Thomas Benjamin Pearman ✠ Richmond, Va.; Medical College of Virginia, Richmond, 1921; member of the Richmond Academy of Medicine and the Southern Medical Association; affiliated with the Retreat for the Sick, Johnston-Willis Hospital, Sheltering Arms Hospital, Medical College of Virginia Hospital and the Grace Hospital, where he died January 12, aged 49, of fibrillation of the heart and hepatic cirrhosis.

Ladislaus Joseph Perenyi, New York; University and Bellevue Hospital Medical College, New York, 1923; member of the American Medical Association; consultant on the staffs of the Mercy and South Nassau Communities hospitals in Rockville Centre; died in Rockville Centre, N. Y., January 19, aged 47, of diabetes mellitus and coronary thrombosis.

Charles Stephen Phalen ✠ Sparta, Wis.; Northwestern University Medical School, Chicago, 1913; served during World War I; vice president of the staff of St. Mary's Hospital, where he died January 30, aged 64, of coronary occlusion.

Wilson Frank Phillips ✠ Boston; Boston University School of Medicine, 1898; formerly assistant professor of theory and practice of medicine at his alma mater; consultant in medicine at the Massachusetts Memorial Hospitals, where he died January 29, aged 74, of coronary thrombosis and bronchopneumonia.

Roland Henry Prien ✠ Gilroy, Calif.; University of Colorado School of Medicine, Denver, 1919; an Affiliate Fellow of the American Medical Assaociation; died January 23, aged 66, of coronary occlusion.

James D. Reid, ✠ Wellsville, Kan.; University Medical College of Kansas City, Mo., 1912; died January 27, aged 65, of carcinoma of the lung.

John Inzer Reid, Montevallo, Ala.; University of Nashville (Tenn.) Medical Department, 1906; member of the American Medical Association; for many years mayor of Montevallo; died in a hospital at Birmingham January 10, aged 65.

John Henry Reynolds, Live Oak, Fla.; University of the South Medical Department, Sewanee, Tenn., 1899; died January 2, aged 73, of arteriosclerosis.

William Weston Reynolds ✠ Meridian, Miss.; Louisville (Ky.) Medical College, 1898; past president of the Lauderdale County Medical Society; formerly county health officer and member of the state board of health; served as superintendent of the Matty Hersee Hospital; on the staff of the East Mississippi State Hospital; for many years surgeon for the Southern Railway; died in Rush's Infirmary February 2, aged 76.

Joseph Bennett Riddle, Morganton, N. C.; Vanderbilt University School of Medicine, Nashville, Tenn., 1898; member of the American Medical Association; surgeon, North Carolina State Hospital, Morganton; for many years affiliated with the Grace Hospital, where he died January 1, aged 76.

John Franklin Ritter, Maquoketa, Iowa; University of Michigan Department of Medicine and Surgery, Ann Arbor, 1895; member of the American Medical Association; died January 29, aged 77, of coronary occlusion.

Clement J. Rider, Bushnell, Ill.; Baltimore Medical College, 1893; died in Des Moines January 28, aged 79, of chronic myocarditis.

Stacy Herman Rinehardt, Harrisburg, Pa.; Jefferson Medical College of Philadelphia, 1909; served during World War I; died February 8, aged 62, of coronary thrombosis.

Sherman T. Rogers, New Albany, Ind.; Eclectic Medical Institute, Cincinnati, 1887; member of the American Medical Association; served as health officer; died in the "Silvercrest" Southern Indiana Tuberculosis Hospital February 6, aged 81.

Hugh Beverly Roney, Pittsfield, Mass.; Hahnemann Medical College and Hospital of Philadelphia, 1909; member of the American Medical Association; on the staffs of the House of Mercy and Hillcrest hospitals; died January 8, aged 60, of heart disease.

Morris Rosenbaum, New York; Columbia University College of Physicians and Surgeons, New York, 1903; specialist certified by the American Board of Ophthalmology; member of the American Academy of Ophthalmology and Oto-Laryngology; on the staffs of the New York Eye and Ear Infirmary and the Mount Sinai Hospital; died February 1, aged 66, of heart disease.

Gerry Weedon Ross, Onsted, Mich.; University of Michigan Department of Medicine and Surgery, Ann Arbor, 1880; president of the Onsted State Bank; died February 5, aged 87, of heart disease.

Oswald Herman Roth, Newark, N. J.; Bellevue Hospital Medical College, New York, 1892; member of the American Medical Association; at one time examining physician at the Essex County Jail and the House of Detention; died February 19, aged 76, of coronary thrombosis.

Charles Dudley Saul, Philadelphia; Hahnemann Medical College and Hospital of Philadelphia, 1901; member of the American Medical Association; formerly clinical professor of medicine at his alma mater; served during World War I; affiliated with St. Luke's and Children's Medical Center; died January 8, aged 66, of heart disease.

Philip Harrison Scherer, St. Louis; St. Louis University School of Medicine, 1914; member of the American Medical Association; fellow of the American College of Surgeons; instructor in surgery at the St. Louis University School of Medicine; assistant surgeon, St. Mary's Group of Hospitals; an officer during World War I; died in the Alexian Brothers Hospital February 6, aged 57, of hemorrhage due to peptic ulcer.

Hugh Murdoch Shannon, El Paso, Texas; Hahnemann Medical College and Hospital of Philadelphia, 1907; member of the American Medical Association; died in the William Beaumont General Hospital, January 27, aged 61, of cerebral hemorrhage and hypertension.

Bennett Marion Shelton ✠ Brownwood, Texas; Baylor University College of Medicine, Dallas, 1918; fellow of the American College of Surgeons; past president of the Brown County Medical Society; served during World War I; served as director of Brown County Water Improvement District and member and president of the school board; president of the Medical Arts Hospital; died January 30, aged 55, of coronary occlusion.

Mathias Joseph Seifert ✠ Chicago; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1901; at one time on the faculty of his alma mater; fellow of the American College of Surgeons; author of several books; on the staffs of St. Mary's of Nazareth Hospital and the Columbus Hospital, where he died January 31, aged 80, of bronchopneumonia and hypernephroma.

Roswell Haydn Smith ✠ Edgartown, Mass.; Middlesex College of Medicine and Surgery, Cambridge, 1922; chairman of the school board; on the staff of the Martha's Vineyard Hospital, Oak Bluffs; died February 12, aged 52, of cerebral hemorrhage.

Edward Henry Spiegelberg ✠ Boscobel, Wis.; Rush Medical College, Chicago, 1906; councilor of the Fourth District of the State Medical Society of Wisconsin; died in Milwaukee January 26, aged 65, of coronary occlusion.

Albert Edward Stickley ✠ Coopersville, Mich.; Grand Rapids Medical College, 1907; veteran of the Spanish-American War and World War I; for many years a member and past president of the board of education; died in the Hackley Hospital, Muskegon, January 23, aged 73, of ruptured aortic aneurysm.

Lydia Webster Stokes, Woodbury, N. J.; Woman's Medical College of Pennsylvania, Philadelphia, 1894; died January 19, aged 76, of carcinoma of the breast.

Clarence Manley Thomas ✠ Pittsburgh; Western Pennsylvania Medical College, Pittsburgh, 1907; served during World War I; chief anesthetist, South Side Hospital; died January 19, aged 64, of coronary thrombosis.

Robert Lester Waite ✠ Hartford, Conn.; Johns Hopkins University School of Medicine, Baltimore, 1909; on the staff of the Hartford Hospital, where he died January 6, aged 64, of arteriosclerotic heart disease.

Allen Augustus Weeden ✠ Woonsocket, R. I.; Tufts College Medical School, Boston, 1905; served during World War I; a medical officer for the North Smithfield draft board during World War II; for many years affiliated with Woonsocket Hospital, where he died January 27, aged 75.

Herbert Q. White, Grand View, Ind.; University of Louisville (Ky.) Medical Department, 1893; served as county coroner; died February 7, aged 76, of heart disease.

Gillespie Blaine Yeaney ✠ Clearfield, Pa.; Western Pennsylvania Medical College, Pittsburgh, 1903; chief of medical staff of the Clearfield Hospital; died January 31, aged 67, of coronary occlusion.

Foreign Letters

LONDON

(From Our Regular Correspondent)

March 15, 1947.

Appalling Corruption in the Nursing Service of the Egyptian State Hospitals

Dr. A. Cecil Alport, a British physician who was professor of clinical medicine and director of the medical unit, King Fuad First Hospital, University of Cairo, Egypt, has in a book entitled "One Hour of Justice, the Black Book of the Egyptian Hospitals," revealed an almost incredible state of corruption in the nursing service which is performed by males, known as tamargis. Briefly, if the patients, who are poor peasants, have not enough money to bribe the nurses they suffer not only neglect but ill treatment. They are robbed and even assaulted. Some develop what the Egyptian professors term "endogenous hospital disease," disease contracted in a hospital, such as dysentery and enteric fever from flies and pneumonia from unheated wards. The poor who can help it never go into the state hospitals. Europeans and Egyptians never send their servants to these hospitals if they can get them, by payment, into the Christian Mission Hospital or other nongovernment hospitals. In the government hospitals the male nurses are blackmailing gangsters of the worst type. They make patients pay for the medicine ordered for them and the food to which they are entitled. Apart from their blackmailing activities the tamargis steal hospital equipment, instruments, medicine and food.

When Professor Alport could no longer endure these and other scandals in hospital administration he sent his resignation to the university authorities. They sent the professor of anatomy to try to induce him to withdraw his resignation, but he refused. The emeritus professor of physiology followed on the same errand, with the same result. Professor Alport was even offered an increase of salary to silence him. In order to obtain some reform of the nursing service he exposed the scandals in a pamphlet, which he had difficulty in circulating, and now in this book. Personal attacks were made on him by the university authorities when they found that they could not shut his mouth. Thus they have not only done nothing to abolish the scandalous ill treatment of the patients in hospitals but have actively supported it. Here is a country the heir to one of the oldest civilizations in the world which has successfully adopted much of European civilization, including modern hospitals, yet treatment is allowed to be reduced to a farce by the corrupt practices of the nurses.

Laboratory Investigations in the Diagnosis of Virus Infections

Discussing laboratory investigations in the Chadwick Lecture, delivered at the Royal Society of Tropical Medicine and Hygiene, Professor S. P. Bedson complained of the delay in the findings of research passing into everyday knowledge. Much of the work of the past fifteen years had gone unnoticed, and insufficient use was made of the diagnostic procedures which virus research had made available. It was still widely believed that all viruses were too small to be seen with the microscope, yet in quite a number of virus diseases microscopic demonstration of the causal agent was of diagnostic value. This held for trachoma and for conditions due to the nearly related virus of inclusion conjunctivitis. The virus of lymphogranuloma venereum could at times be demonstrated in smears made from inguinal buboes, which occurred in many cases of infection with this virus. Recent work had demonstrated the diagnostic value of smears made from the skin lesions of smallpox. Even when demonstration of the virus by the microscope could not be achieved, histologic changes, such as inclusion bodies, could be looked for. They were always suggestive of a virus infection, and in certain instances, such as the Negri body in rabies, they were diagnostic.

Valuable though microscopy might be in the laboratory investigation of virus disease, as in any infection, the aim of the laboratory should be the isolation and identification of the causal agent. In the case of viruses this entailed the injection of experimental animals or eggs and establishing the viruses preparatory to their study. But unfortunately quite a number of viruses affecting man were so specifically adapted to him that it was impossible to grow them apart from human tissues, and even when animals or the egg were suitable the time consumed in identifying the virus made the procedure of little use in immediate diagnosis. Nevertheless, whenever the diagnosis was in doubt attempts to isolate and identify the virus should be made. It was still far from being generally appreciated that the serologic reactions employed in bacteriology were equally applicable to the identification of viruses or the diagnosis of virus disease. Of these reactions the complement fixation test was probably the most valuable for virus work. It could be used either for the demonstration of the causal virus, as in the diagnosis of smallpox, or for the detection of antibody produced in response to infection, as in influenza, psittacosis, lymphocytic choriomeningitis, lymphogranuloma venereum or mumps.

THE NETHERLANDS

(From Our Regular Correspondent)

AMSTERDAM, Feb. 15, 1947.

A New Vitamin in Butter

In the laboratories for physiologic chemistry of the University of Amsterdam research has been in progress during recent years under the direction of Professor B. C. P. Jansen on the favorable influence of butter fat on the growth of young rats. Professor Jansen and Dr. J. Boer found that summer butter fat showed a more favorable influence on the growth of young rats than other fats, even winter butter fat. The factor responsible for this action is not identical with any of the known vitamins. The glycerides of the fatty acids from summer butter have, if the unsaponifiable fraction from summer butter is added, a growth promoting action equal to that of summer butter. The factor responsible for this better growth apparently is an unsaturated fatty acid, because the growth promoting action of summer butter fat and of the fatty acids from summer butter fat disappear on hydrogenation. This cannot be due to a diminished food intake or to poor absorption of the fat in the ration having a rather high melting point.

A number of portions of about 2,000 Gm. of methylesters of fatty acids from summer butter were submitted to accurate fractional distillation. The fraction with eighteen carbon atoms which was isolated by fractional distillation of the methylesters of the fatty acids from summer butter appeared to have growth promoting properties; the corresponding fatty acid fraction of the hydrogenated fatty acids did not. Dr. A. J. Kentie, who describes in a recent dissertation these researches, concludes that vaccenic acid seems to possess all the properties mentioned. Vaccenic acid, discovered in 1928, can be produced from Chinese wood oil. Professor E. Brouwer of the Agricultural University of Wageningen has found that the highest concentration of vaccenic acid is in summer butter fat. This explains why the growth promoting factor of summer butter exceeds the growth promoting factor of winter butter. A fraction consisting mainly of vaccenic acid, separated from the fatty acids of summer butter, appeared to have growth promoting properties if added in a concentration of 1 per cent to rapeseed oil. Probably vaccenic acid is one of the growth promoting factors present in summer butter.

133
947

New Fees for Dutch Doctors

A large number of mutual assurance foundations exist in the Netherlands which have contracts for the medical aid and assistance of their members with 6,300 Dutch doctors. Only persons with limited revenues can affiliate with such an assurance institute, controlled by the state. Those who are members of a mutual assurance foundation are free to choose or discharge their house doctor. The doctor has to give all medical treatment and aid. Patients can call him at their home whenever they want. Medical treatment by specialists and care in a hospital or sanatorium is also provided by the foundation, if judged necessary by the house doctor.

For all patients who have chosen a special doctor, the doctor was paid a certain annual amount. In the cities a doctor received 4 guilders for adults for a whole year; for children only 1 guilder. A doctor could have up to 2,500 patients affiliated with a mutual assurance company.

Persons with an income higher than the limit fixed by the government and the assurance institutes for affiliating to their foundations had to pay for every visit to their doctor or for every call at their home. The fee is about $1 (it takes 2.68 guilders to equal a dollar).

The contracts by the 172 existing mutual foundations with the doctors was fixed long before the war. But during and after the war the limit of revenues for those who wanted to become affiliated with an assurance foundation were raised from 2,200 guilders to 3,000 guilders and recently to 3,750 guilders a year ($1,500). The raising of the income level was explained by the fact that many persons who could afford to pay their doctor for every treatment before the war, were no longer able to do so because of the increased cost of living.

For the doctors the raising of the income level meant that fewer persons than before were now paying for every treatment, the income of the doctors thus decreasing. Therefore the 6,300 doctors who had contracts with the assurance foundations gave warning of ending their existing contracts on Nov. 1, 1946, saying that the rising cost of living required them to ask for new contracts with better conditions. They continued, however, to give their medical assistance to all their patients.

After negotiations by representatives of the government, the Dutch doctors and the assurance institutes, new contracts for doctors and specialists were fixed on January 20. During 1947 the doctor will receive 4.68 guilders for each patient who chooses him as physician. After 1947, 4.25 guilders will be paid. The fee for children will be equal to that for adults. Although the doctors are not fully satisfied, they hope that living conditions for themselves will be better than before.

Death of Professor van der Wielen

The death was announced of P. van der Wielen, emeritus professor of pharmacy. During his long tenure van der Wielen earned a great reputation. He lectured on pharmacy both to the candidate apothecaries and to medical students. He contributed in many publications to the methods of drug control and pharmaceutic chemistry. In several volumes he commented on the Netherlands Pharmacopeia. One of his services to the medical profession consisted in the joint editorship of the Pharmacotherapeutisch Vade Mecum, whose other editor was Dr. Pinkhof, a victim of the Nazi occupation. This handy book is a compilation of descriptions of almost all available drugs and pharmaceutic preparations, with concise comments on their chemical, pharmacologic and toxicologic properties and suggestions as to their clinical application. This vade mecum has reached many editions and it was kept up to date. There are few practitioners or specialists who do not keep this book close at hand to afford them information on drug therapy. The reliability of this information greatly adds to the safety of therapeutic measures in this country.

International Congress for Orthopedic Surgery and Traumatology at Amsterdam

In September 1948 an international congress for orthopedic surgery and traumatology will be held at Amsterdam. Dr. Henry W. Meyerding of the Mayo Clinic will be chairman of the congress.

SWEDEN

(From Our Regular Correspondent)

STOCKHOLM, March 18, 1947.

New Mental Hospitals

As previously mentioned, the Royal Swedish Medical Board has drawn up a five year plan for the building of new hospitals and the general improvement of the socialized medical service in Sweden. Included in this plan is a proposal for the construction of two special mental hospitals, intended for those sentenced by the courts to psychopathic care and those coming from social welfare institutions, such as alcoholic addicts. As the situation now stands, persons "sentenced" to mental care are sent to special divisions of the insane asylums. The disadvantages of this system are self evident. The patients themselves feel degraded and the institutions have a difficult time taking care of them in that special safety measures must be taken to keep them from running away and so on. These patients do not belong in an ordinary insane asylum, and the medical board, aware of the need for improving the situation, has proposed the construction of two hospitals, preferably in the neighborhood of large industrial towns. Some sort of employment in industry would promote readjustment into society. By building small pavilions and independent "boarding houses" as part of the institutions, the patients could adjust themselves gradually to society, thus eliminating the dangers inherent in a sudden change from a sheltered to a free life.

These new hospitals are still on paper and will be a long time in maturing to reality. Owing to the need for general hospitals, especially in consideration of the health insurance reform of 1950, which will send even more people into the hospitals, it remains to be seen where on the list of new construction these mental hospitals will stand.

Report of Study of Day Nurseries

Sweden has a number of state aided day nurseries for children in large cities throughout the country, not nearly enough for the demand, of course, but relatively more than exist in the United States. A social welfare investigating committee recently made a disturbing report on the incidence of disease in these nurseries. On the basis of a study made of one of the Stockholm nurseries last fall, it was stated that the condition of the children's health was not satisfactory. The nursery children were significantly more susceptible to disease than the control group of children who stayed at home, and the number of cases of illness was far greater. Many of the nursery children have had colds for long periods and many have constant fever. Ear infections are far more numerous. Sinus and kidney inflammations have appeared among the nursery children, but not in the control group. Bacteriologic studies revealed that certain types of bacteria, which do not ordinarily appear in epidemic form, have caused minor epidemics at the nursery and that children are hardly recovered from one infection before they contract another or are perhaps infected with several types of bacteria simultaneously. Recommendations were made for the installation of ultraviolet lamps and the impregnation of floors and textiles with oil to reduce the risk of infection. With such a large percentage of Swedish mothers out at work every day, these nurseries are of the utmost importance in the present state of society.

V 1
194

Correspondence

SENSITIVITY TO SULFONAMIDES OR PENICILLIN

To the Editor:—After reading the report of the case reported on page 849 of the March 22 issue of THE JOURNAL, "Reactions to Penicillin," I was impressed with the fact that the case so described as a serum sickness type of reaction to penicillin was, in reality, an acute reaction to sulfathiazole.

According to the history, the patient went through the first stage of thoracoplasty on Aug. 13, 1946. At that time 3 Gm. of sulfathiazole crystals was sprinkled in the wound. On September 8 the second stage was accomplished with 3 Gm. of sulfathiazole crystals again sprinkled in the wound. The untoward symptoms began on the day of surgery. The penicillin had been given for only three days prior to surgery. The time element evidence points to an immediate reaction to sulfathiazole. Serum sickness reactions usually begin seven to ten days after the initial administration.

I have seen several cases like the one described as a result of the surgical use of sulfathiazole cyrstals. The literature is full of febrile reactions, dermatitis and other conditions from the topical application of the sulfonamide powders. In fact, the finger of suspicion points to this practice as a factor in necrotizing arteriolar lesions.

This note is not written to discredit the use of procaine hydrochloride intravenously in the treatment of drug reactions. I feel that this method of therapy is worthy of full consideration. However, one should not call this a serum sickness type of reaction to penicillin without ruling out the possibility of the sulfathiazole being the offender, especially in view of the high sensitizing index of sulfonamides as compared with the relatively low sensitizing index of penicillin.

LEWIS E. ABRAM, M.D., Cleveland.

PROCAINE FOR URTICARIA FROM PENICILLIN

To the Editor:—Concerning the article on the use of procaine hydrochloride in urticarial reactions from penicillin (Dressler and Dwork, THE JOURNAL, March 22), a word of caution should be offered: The effect of this medication in hives is indeed startling and probably excels in efficacy anything else recommended for urticaria. In Europe this method has also been employed on a large scale in the treatment of intractable asthma with remarkable results. It should be borne in mind, however, that sensitivity to cocaine and related drugs is not uncommon (Waldbott, G. L.: So-Called Thymic Death, *Arch. Otolaryng.* **17**:549 [April] 1933). The literature reveals many instances of fatal anaphylaxis when, during administration of local anesthesia, a vein was accidentally punctured and relatively small amounts of the anesthetic were introduced into the blood stream of patients who were sensitive to the drug. I have recently been called to see a patient who had been given approximately 0.5 Gm. of procaine hydrochloride in 250 cc. of saline solution intravenously for the relief of urticaria following the recommendation of State and Wangensteen (THE JOURNAL, April 13, 1946). She developed severe allergic shock and was saved only by the prompt action of the attending physician. Sensitization to the drug is particularly apt to develop in patients with chronic urticaria, since they are liable to have second and third injections of procaine after intervals of a few weeks in a manner similar to the one of producing anaphylaxis in animals. Preliminary skin tests for these drugs are unreliable, especially when the skin is covered with urticarial lesions.

GEORGE L. WALDBOTT, M.D., Detroit.

EFFECTS OF HEXYLRESORCINOL ON SURFACE TENSION

To the Editor:— Please permit me to correct an opinion expressed by Dr. Gilbert J. Thomas in his discussion on page 587 of the March 1 issue of THE JOURNAL. He said "Hexylresorcinol in 1:1,000 solution changed the physical properties of the urine by increasing the surface tension."

I think that if Dr. Thomas was to investigate he would find that hexylresorcinol decreases surface tension. Although the disinfectant powers of this compound have been attributed by some to its ability to reduce surface tension, it is interesting to note that some other surface tension reductants are not as germicidal as hexylresorcinol even though they may produce an equal reduction in surface tension in the concentration used. However, in a homologous series, surface tension reducing power shows a definite relationship to bactericidal activity. These facts suggest a specific activity of the hexylresorcinol molecule over and beyond its action on surface tension. Therefore I would say that this compound does not act merely as a physical agent, as Dr. Thomas suggested.

This subject is discussed on page 110 of "A Textbook of Bacteriology" by Zinsser and Bayne-Jones (ed. 8).

HUGH A. INNESS-BROWN JR., Vermillion, S. D.

PROLONGED REACTION TO BENADRYL

To the Editor:—THE JOURNAL has come to occupy a well deserved place as the major, if not the only, medical periodical read by the average general practitioner in this country. This places a heavy responsibility on contributors, as their procedures, technics, dosages and sometimes even minor suggestions may be adopted in toto by a practitioner too busy to investigate further. For this reason it is disturbing to us as pharmacologists to see important fundamental principles overlooked in an article published in THE JOURNAL.

In a communication entitled "Prolonged Reaction to Benadryl" by Samuel Schwartzberg and Darrell Willerson (THE JOURNAL, February 8, p. 393) the authors suggest treatment of a Benadryl reaction with intravenous histamine. This may seem a logical procedure when one thinks of Benadryl only as an antihistamine drug; but drugs, especially those with complex chemical formulas, seldom act on only one system or mechanism. It is probable that most of the toxic reactions to Benadryl involve mechanisms entirely distinct from its antihistamine activity, and injection of histamine might actually be harmful in such cases. Histamine causes dilatation and increased permeability of blood vessels—a picture closely resembling clinical shock. In a case of shocklike reaction to Benadryl such as that described in the same issue of THE JOURNAL by Drs. Geiger, Rosenfield and Hartman, injection of histamine could aggravate the condition, with a possibly fatal outcome.

It therefore seems to us that when the authors made their suggestion, which may be worthy of consideration in their case, they should have added a strong word of caution. The radical therapy proposed should certainly be used only when all provisions are made for handling untoward reactions which might follow. The use of intravenous histamine has no theoretical justification in most reactions to Benadryl.

NORMAN A. DAVID, M.D.
NORMAN W. KARR, PH.D., M.D.
Department of Pharmacology,
University of Oregon Medical School, Portland, Ore.

Bureau of Legal Medicine and Legislation

MEDICOLEGAL ABSTRACTS

Workmen's Compensation Act: Conflict of Medical Testimony.—The petitioner filed a claim for an award under the workmen's compensation act for injuries sustained in the course of his employment with the Aluminum Company of America. An award in his favor was reversed on rehearing before the commission, so the petitioner appealed to the Supreme Court of Arizona.

In May 1943 the petitioner was struck on the left side of his back, with considerable force, by a 2 by 12 plank, causing an abrasion about 6 inches long. X-rays taken on the day of the accident disclosed no fracture, bone injury or tearing of the tendons or tissues. About a week later, however, additional x-rays showed that the petitioner had a rather old and well developed case of arthritis existing in two forms, hypertrophic and rheumatoid. Following the injury the petitioner suffered from pain, and finally, in July 1943, quit his employment because of his condition. On July 22, 1944 the compensation commission granted an award for temporary partial disability for a period not to exceed sixty months subsequent to June 20, 1944. On rehearing the commission held that the petitioner had no disability resulting from the accident after June 19, 1944 and it therefore set aside its previous award. On appeal to the Supreme Court, the sole question was whether or not the evidence was of such a character as to justify the final finding of the commission.

The parties agreed that petitioner was totally disabled because of pain resulting from rheumatoid arthritis and that at the time of the accident the petitioner was suffering from both hypertrophic and rheumatoid arthritis. The medical experts agreed that petitioner's disability as of June 1944 had no relation to the hypertrophic form of arthritis; that the infectious or rheumatoid arthritis is progressing; that the accident did not cause or bring on the rheumatoid arthritis; that hypertrophic arthritis is a chronic generally nondisabling disease or condition of the joints indicated by bony spars or spurs at the site of the attachments of tendon, fascia or ligament and usually due to continued irritation or strain; that rheumatoid arthritis, on the other hand, is "a chronic disease of the joints . . . marked by inflammatory changes in the synovial membranes and articular structures and by atrophy and rarefaction of the bones," is of an infectious character, produces inflammation, and is characterized by pain.

Some of the medical experts testified that the rheumatoid arthritis at the time of the accident was latent in character, and that the accident caused it to flare up, or that it was aggravated by the injury. They took the position that, since petitioner was not disabled by the disease at the time of the injury but became disabled shortly thereafter, the injury was the activating cause of the pain and therefore the disability was produced by the accident. Approximately an equal number of other medical experts testified, however, that, there being no tearing of ligaments, tendons or tissues or fracture of bones, the injury was not severe enough to light up or activate the existing disease. It was the position of these doctors that the disease condition of petitioner's spine on the date of the accident made it more susceptible to pain than would be a normal spine and in addition that the pain resulting from the accident might therefore continue for a longer period than if the spine were in a healthy condition. It was their theory that petitioner's condition as of June 1944 must be attributed solely to the progress of the disease itself and not in any way to the accident.

It appears, said the Supreme Court, that the different theories of the medical experts are based on what would seem to be not only admitted facts but reasonable hypotheses. Whether the rheumatoid arthritis was permanently activated by the injury is largely a medical question. It would also seem to be largely a matter for expert medical opinion when the effects of an injury to a diseased spine would subside and whether the pain and consequent disability as of a year after the accident was from the effects of the injury itself or was a result of the progress of the disease. In a prior Arizona case the rule has been established that where the determination of a question of disability must rest on expert medical testimony, and the opinions of the experts are based on supporting facts and logical theories, this is reasonable evidence for the commission's consideration. Here, pointed out the Supreme Court, the evidence is conflicting. The commission might have followed either of the theories advanced by the medical witnesses. Since the opinions of the medical experts which were apparently followed by the commission conformed to the rule of the cases mentioned, the Supreme Court concluded that it could only affirm the award. Accordingly the award in favor of the petitioner was affirmed.—*Lewis v. Industrial Commission, 173 P. (2d) 639 (Arizona, 1946).*

Pharmacists: Liability for Error in Filling Prescription.—The defendant, a licensed pharmacist, in filling a physician's prescription calling for the delivery of 21 grains of sulfathiazole, in powder form, misread the written prescription and delivered 147 grains in tablet form; and the purchaser consented to grind the tablets into powder. As a result of the defendant's error the patient for whom the drug was intended, an 8 months old infant, was given doses containing 21 grains of the drug whereas the prescription called for doses of 3 grains. After the ingestion of six doses the baby died. The defendant was indicted on two counts: (1) manslaughter in the second degree and (2) violation of section 1742 of the Penal Law prohibiting the delivery of a larger quantity of drugs than was prescribed. The trial court found the defendant guilty on both counts and the defendant appealed to the supreme court, appellate division, second department New York. The court said that the evidence established that the defendant made a mistake in reading the prescription but that it failed to establish any culpable negligence within the contemplation of the manslaughter statute. Accordingly the verdict of guilty on the first charge was set aside and the verdict of guilty on the second charge unanimously affirmed.—*People v. Greenwald, 65 N. Y. S. (2d) 193 (New York, 1946).*

Medical Examinations and Licensure

COMING EXAMINATIONS AND MEETINGS

BOARDS OF MEDICAL EXAMINERS
BOARDS OF EXAMINERS IN THE BASIC SCIENCES

Examinations of the boards of medical examiners and boards of examiners in the basic sciences were published in THE JOURNAL, April 19, page 1239.

NATIONAL BOARD OF MEDICAL EXAMINERS

NATIONAL BOARD OF MEDICAL EXAMINERS: *Parts I and II.* Various centers, June 16-18. *Part III.* Various centers, June. Durham, Oct. 21-23. Sec., Mr. Everett S. Elwood, 225 S. 15th St., Philadelphia 2.

EXAMINING BOARDS IN SPECIALTIES

AMERICAN BOARD OF ANESTHESIOLOGY: Part II. *Oral.* Cleveland, Oct. 5-11. Sec., Dr. P. M. Wood, 131 Riverside Dr., New York 24.

AMERICAN BOARD OF DERMATOLOGY AND SYPHILOLOGY: *Oral.* New York City, April 25-27. Sec., Dr. George M. Lewis, 66 E. 66th St., New York 21.

AMERICAN BOARD OF NEUROLOGICAL SURGERY: Oral. Chicago, June 4-5. Sec., Dr. Paul C. Bucy, 912 S. Wood St., Chicago.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY: *Part II.* Pittsburgh. June 1-7. Sec., Dr. Paul Titus, 1015 Highland Bldg., Pittsburgh.

AMERICAN BOARD OF OPHTHALMOLOGY: Philadelphia, June 15-19. Chicago, October 6-12. Sec., Dr. S. Judd Beach, 704 Congress St., Portland, Me.

AMERICAN BOARD OF ORTHOPAEDIC SURGERY: Part I. St. Louis, May 1-2. Part II. Chicago, Jan. 22-23. Final date for filing applications is Sept. 15, 1947. Sec., Col. F. M. McKeever, 1136 W. Sixth St., Los Angeles 14.

AMERICAN BOARD OF OTOLARYNGOLOGY: Chicago, Oct. 7-11. Sec., Dr. D. M. Lierle, University Hospitals, Iowa City, Ia.

AMERICAN BOARD OF PEDIATRICS: Effective May 1, application fee will be $125.

AMERICAN BOARD OF PLASTIC SURGERY: Examinations are given in April and November of each year in the home town of applicants. Applications should be sent to Sec., Dr. Robert H. Ivy, c/o Clerical Secretary, 4647 Pershing Ave., St. Louis 8.

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY: New York, December. Final date for filing application is Sept. 15. Sec., Dr. Francis J. Braceland, 102-110 Second Ave., S. W., Rochester, Minn.

AMERICAN BOARD OF SURGERY: Final date for filing application for the next written examination is July 1. Sec., Dr. J. Stewart Rodman, 225 S. 15th St., Philadelphia.

AMERICAN BOARD OF UROLOGY: Chicago, February. Final date for filing application is Nov. 1. Sec., Dr. Harry Culver, 1409 Willow St., Minneapolis 4.

Current Medical Literature

AMERICAN

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Titles marked with an asterisk (*) are abstracted below.

American Journal of Hygiene, Baltimore

45:1-122 (Jan.) 1947

Epidemiology of Terminal Bronchopneumonia: I. Significance of Postmortem Cultures in Determination of Etiology of Terminal Pneumonia. W. G. Smillie and Dorothy R. Duerschner.—p. 1.

Id.: II. Selectivity of Nasopharyngeal Bacteria in Invasion of Lungs. W. G. Smillie and Dorothy R. Duerschner.—p. 13.

Salmonella Types Encountered by the 15th Medical General Laboratory. D. W. Bruner and B. J. Joyce.—p. 19.

Susceptibility of Different Species of Avian Malarial Parasites to Drugs. E. H. Dearborn and E. K. Marshall Jr.—p. 25.

Further Studies on Stability of Resistance to Common Cold: Importance of Constitution. F. Sargent II, Olive M. Lombard and Virginia W. Sargent.—p. 29.

Epidemiologic Aspects of Outbreak of Infectious Hepatitis. R. E. Trussell.—p. 33.

Effect of Four Different Therapies on Relapse Rate of Vivax Malaria. W. Trager, F. B. Bang and N. G. Hairston.—p. 43.

Isolation of Typhus Rickettsiae from Rat Mites Liponyssus Bacoti in Peiping. Wei-T'ung Liu.—p. 58.

Physiologic Factors Which Influence Infection of Aedes Aegypti with Plasmodium Gallinaceum. W. Hovanitz.—p. 67.

*Serologic and Epidemiologic Studies on Primary Atypical Pneumonia and Related Acute Upper Respiratory Disease. M. D. Eaton and W. van Herick.—p. 82.

Effect of Vaccination on Incidence of Influenza B. G. K. Hirst, A. Vilches, O. Rogers and C. L. Robbins.—p. 96.

Prolonged Storage of Human Pathogenic Protozoa with Conservation of Virulence: Observations on Storage of Helminths and Leprospiras. D. Weinman and Joan McAllister.—p. 102.

Primary Atypical Pneumonia.—On the basis of antigenic composition, host range, pathogenicity and other properties, Eaton and van Herick point out that the virus of atypical pneumonia is distinct from the viruses of influenza A and B, the viruses of the psittacosis group, the pneumonia virus of mice and the common nonbacterial infectious agents of the respiratory tracts of cotton rats and hamsters. Their results permit a more accurate evaluation of the etiologic relationship of the virus to epidemic and sporadic acute respiratory disease with or without pneumonia. Virus neutralization tests were done with paired acute phase and convalescent serums from 213 persons with various types of respiratory disease. Significant increases in titer of fourfold or greater were found in the serums of 52 of the 84 persons with primary atypical pneumonia and in the serums of 15 of the 77 with undifferentiated upper respiratory infection. As controls, 52 pairs of serum specimens from persons with respiratory diseases were also examined. Only one, the serum of a patient with type A influenza, showed a fourfold increase in neutralizing antibodies. Nearly all persons having primary atypical pneumonia with positive cold isohemagglutinations and with significant titers of agglutinins for the indifferent streptococcus number 344 also had definite increases in virus neutralizing antibodies. In four localized epidemics of acute respiratory illness associated with pneumonia occurring in 1941 and 1942 a high proportion of the cases showed positive neutralization with significant increase in titer of antibodies for the atypical pneumonia virus. Agglutination of streptococcus number 344 was found in about half the cases in the two outbreaks among civilians and in less than 10 per cent of the cases in the other two outbreaks, which were at army camps. The acute phase antibody levels in persons with atypical pneumonia or upper respiratory infection and positive virus neutralization were, on the average, lower than in those who had other respiratory diseases with negative virus neutralization.

American Journal of Medical Sciences, Philadelphia

213:1-128 (Jan.) 1947

Migrainous Personality and Constitution: Essential Features of the Disease; Study of 500 Cases. W. C. Alvarez.—p. 1.

*Fatal Infection with Poliomyelitis Virus in Laboratory Technician: Isolation of Virus from Lymph Nodes. H. A. Wenner and J. R. Paul.—p. 9.

Gynecomastia Due to Malnutrition. G. Klatskin, W. T. Salter and F. D. Humm.—p. 19.

Mild Rheumatic Reaction in Coast Guard Recruits. H. Poliakoff.—p. 37.

Blood Pressure Studies in 100 Cases of Coronary Occlusion with Myocardial Infarction. W. N. Chambers.—p. 40.

Specific Dynamic Action as Means of Augmenting Peripheral Blood Flow: Use of Aminoacetic Acid. R. Gubner, J. R. Di Palma and Elizabeth Moore.—p. 46.

Evaluation of Immune Serum Globulin as Prophylactic Agent Against Homologous Serum Hepatitis. G. G. Duncan, H. A. Christian, J. Stokes Jr., W. F. Rexer, J. T. Nicholson and A. Edgar.—p. 53.

Pathology of Experimental Frostbite. N. B. Friedman, K. Lange and D. Weiner.—p. 61.

Use of Posterior Pituitary Extract (Pituitrin) to Measure Renal Function. S. F. Horne and L. M. Morris.—p. 68.

Thiouracil in Thyrotoxicosis: Results of Prolonged Treatment in 35 Cases. E. Rose and Jeannette McConnell.—p. 74.

Relationship of Bromsulphalein Retention to Fever of Natural P. Falciparum Malaria. T. E. Machella, with technical assistance of R. Fine and D. Burgoon.—p. 81.

Rheumatoid Arthritis. A. D. Wallis.—p. 87.

Diagnosis of Pulmonary Disease. L. L. Friedman.—p. 97.

Personality Repercussions of Anterior Poliomyelitis: Review of Literature. C. E. Stanfield.—p. 109.

Psychosomatic Relationships in Acute Anterior Poliomyelitis. F. G. Ebaugh and C. S. Hoekstra.—p. 115.

Fatal Infection with Poliomyelitis Virus in Laboratory.—Wenner and Paul report a fatal case of poliomyelitis which occurred in a laboratory worker. It is probable, although not definite, that this man acquired his infection as a result of exposure to poliomyelitis virus in the laboratory. Prior to his infection he was working with human infectious material and with strains of poliomyelitis virus in their early monkey passage. Poliomyelitis virus was isolated from the throat (during life) and at necropsy from the central nervous system, the washed wall of the duodenum, mesenteric lymph nodes and some of the right axillary lymph nodes. Just prior to his illness he sustained an injury to his skin on the right wrist.

American Journal of Medicine, New York

2:1-130 (Jan.) 1947

*Penicillin Therapy of Scarlet Fever and Streptococcus Carrier. R. Jennings and E. D. DeLamater.—p. 1.

Transfer of Beta Hemolytic Streptococci by Shaking Hands. M. Hamburger Jr.—p. 23.

*Clinical and Pathologic Findings in Cases of Truncus Arteriosus in Infancy. Helen B. Taussig.—p. 26.

Influenza: Preliminary Statewide Survey Using Routine Blood Specimens. G. Dalldorf and Christine E. Rice.—p. 35.

Rheumatoid Arthritis: Diagnostic Significance of Focal Cellular Accumulations in Skeletal Muscles. G. K. DeForest, H. Bunting and W. E. Kenney.—p. 40.

Diagnosis of Guillain-Barré's Disease. J. R. Brown and A. B. Baker.—p. 45.

Agranulocytosis Caused by Thiouracil: Review of 59 Cases in Literature and Report of 2 Additional Cases. J. H. Morton.—p. 53.

Penicillin Therapy of Scarlet Fever and Streptococcus Carrier.—Jennings and DeLamater present an extensive bacteriologic and clinical study of an epidemic of streptococcic disease, including scarlet fever, which was caused by a sulfadiazine-resistant strain of group A, type 17, hemolytic streptococcus. The epidemic occurred in young men of military age. A comparison of the complication rates shows complete parallelism with the relative severity of each clinical entity, the rate being highest for scarlet fever and lowest for "nasopharyngitis." Comparison of the clinical response to penicillin and sulfadiazine shows sulfadiazine to be ineffective and penicillin to be dramatic in its relief of symptoms.

Truncus Arteriosus in Infancy.—Of 2 infants with truncus arteriosus, 1 had bronchial arteries and showed intense cyanosis; the other, whose arteries arose directly from the aorta, did not have cyanosis. In both infants the contour of the heart in the left anterior oblique position was identical. In each infant the right ventricle extended out abruptly from the aorta to the anterior chest wall as a shelf. At necropsy the structures of the ventricles and their relation to the truncus arteriosus were found to be identical. Therefore Taussig believes that

this contour is characteristic of a truncus arteriosus in infancy in which the ventricles are normally formed and in which the aorta overrides the ventricular septum and receives blood from both ventricles.

American Journal of Physiology, Baltimore

148:1-258 (Jan.) 1947. **Partial Index**

Measurement of Stroke Volume from Pressure Pulse. W. F. Hamilton and J. W. Remington.—p. 14.
Quantitative Calculation of Time Course of Cardiac Ejection from Pressure Pulse. J. W. Remington and W. F. Hamilton.—p. 25.
*Comparison of Nutritive Value of Fats When Fed Alone or When Fed with Sucrose or Lactose. B. U. Ershoff and H. J. Deuel Jr.—p. 45.
*Thiamine Deficiency and Specific Dynamic Effect of Diet High in Carbohydrate. G. C. Ring.—p. 51.
Renal Regulation of Water and Some Electrolytes in Man, with Special Reference to Their Relative Retention and Excretion. A. V. Wolf. —p. 54.
Mechanism of Prolonged Fluorescein Circulation Time in Experimental Traumatic Shock. S. C. Wang, E. E. Painter and R. R. Overman. —p. 69.
Relation of Maternal Blood Flow within Uterus to Change in Shape and Size of Conceptus During Pregnancy: Physiologic Basis of Uterine Accommodation. S. R. M. Reynolds.—p. 77.
Long Term Acclimatization to Heat. W. R. Christensen.—p. 86.
Peripheral Motion Acuity of 50 Subjects. F. N. Low.—p. 124.
*Effect of Blood Carboxyhemoglobin Concentration on Hypoxia Tolerance. G. C. Pitts and N. Pace.—p. 139.
Increase in Hypoxia Tolerance of Normal Men Accompanying Polycythemia Induced by Transfusion of Erythrocytes. N. Pace, E. L. Lozner, W. V. Consolazio, G. C. Pitts and L. J. Pecora.—p. 152.
Effects of Asphyxiation and Narcosis on Peripheral Nerve Polarization and Conduction. E. B. Wright.—p. 174.
Influence of Age on Hemoconcentrating Responses of the Dog. H. E. Ederstrom and B. DeBoer.—p. 193.
Quantitative Relationship Between Calcium and Prothrombin. A. J. Quick.—p. 211.
Pancreatic Juice is a Rich Source of Anti-Fatty Liver Factor. M. L. Montgomery, C. Entenman and I. L. Chaikoff.—p. 239.
Influence of Liver on Shock Produced by Extracts of Certain Parasites. A. Grana, F. C. Mann and H. E. Essex.—p. 243.
Effect of Explosive Decompression on Cerebrospinal Fluid Pressure. W. V. Whitehorn, A. Lein, A. Edelmann and F. A. Hitchcock.—p. 253.

Nutritive Value of Fats with Sucrose or Lactose.—Ershoff and Deuel report observations on male and female rats which were fed diets containing 70 per cent sugar (lactose or sucrose) and 30 per cent fat (butter fat, margarine fat, corn oil or cottonseed oil). When lactose was the dietary carbohydrate, survival was significantly longer on rations containing margarine fat or butter fat than on diets containing corn oil or cottonseed oil. With sucrose as the dietary carbohydrate, no significant differences in length of survival were observed. Male and female rats were fed diets consisting of a single fat. With female rats of the U. S. C. strain, length of survival was longest with butter fat as compared with lard, olive oil, corn oil, margarine fat, soybean oil, wheat germ oil and cottonseed oil groups. With females of the Sprague-Dawley strain, results on butter were significantly better than with margarine fat, corn oil or cottonseed oil. Significant differences in length of survival were not observed in male rats fed these fats. Periods of survival of male rats on sugar-fat mixtures as well as on exclusive fat diets were longer than those of female rats.

Thiamine Deficiency and Diet High in Carbohydrate.—Ring says that the specific dynamic action of a diet high in carbohydrate and containing adequate thiamine is about twice as large as that of a similar diet without thiamine. He found that 1 mg. of thiamine added to a kilogram of this diet did not produce as large a specific dynamic action as 2 or more milligrams.

Blood Carboxyhemoglobin Concentration and Hypoxia.—According to Pitts and Pace the carbon monoxide concentrations which obtain in some aircraft may lead to concentrations of at least 12 per cent carboxyhemoglobin in the pilot's blood under operating conditions. For military reasons a study was initiated on the effects of such blood carboxyhemoglobin concentrations at intermediate altitudes where airborne personnel do not ordinarily use oxygen breathing equipment but, nevertheless, suffer reduced arterial oxygen saturations. Studies were made on a group of 10 normal men. On the basis of the changes in pulse rate it was possible to derive a quantitative estimate of the effect of blood carboxyhemoglobin on hypoxia tolerance. The increment in response to 1 per cent increase in blood carboxyhemoglobin was equal to that obtained by raising a normal group 335 feet in pressure altitude. This value was determined for the altitude range of 7,000 to 10,000 feet and for increases in blood carboxyhemoglobin of at least 13 per cent.

American Journal of Public Health, New York

37:1-138 (Jan.) 1947. **Partial Index**

Foreign and Domestic Trends in Diphtheria. G. W. Anderson.—p. 1.
*Rhus Dermatitis as Public Health and Health Education Problem. C. E. Turner.—p. 7.
*Present Status of Control of Air Borne Infections. J. E. Perkins and others.—p. 13.
Merit System Administration in Official Health Agencies. J. W. Mountin, Bess A. Cheney and D. F. Simpson.—p. 23.
Achievements of UNRRA as International Health Organization. W. A. Sawyer.—p. 41.
Report of Chairman of Executive Board of American Public Health Association to Governing Council 1945-1946. A. Wolman.—p. 59.

Rhus Dermatitis.—Turner says that preventive hygiene and attempted desensitization have not proved effective in preventing rhus dermatitis. The effectiveness of two new chemical herbicides, ammonium sulfamate and 2-4 dichlorophenoxyacetic acid, which have just come into use, provide the first really promising solution of this public health problem. Health department leadership and the cooperative efforts of community agencies can reduce the now prevalent dermatitis to a relatively rare illness.

Control of Air Borne Infection.—The Subcommittee for the Evaluation of Method of Control of Air Borne Infections has summarized its group judgment on the control of air borne infections. The oiling of floors, blankets and bedding has now developed to the point of practical application in the suppression of dust. Such measures reduce bacterial contamination of the air, but there is as yet insufficient evidence that they prevent disease. Dust suppression should be applied wherever practicable in conjunction with ventilation, ultraviolet irradiation and disinfectant vapors. The available evidence strongly indicates that methods of air disinfection (ventilation, ultraviolet irradiation and glycol vapors) are useful adjuvants to aseptic technics in the reduction or elimination of air borne infections in operating rooms and in contagious disease and pediatric wards. It is not yet possible to compare the relative efficiency of ultraviolet irradiation and glycol vapors. The general use of ultraviolet irradiation or disinfectant vapors in schools, barracks and specialized industrial environments is not justified at the present time. There is no justification for the indiscriminate use of ultraviolet light or other methods for disinfecting air in homes, offices or places of public congregation.

Am. J. Roentgenol. & Rad. Therapy, Springfield, Ill.

57:1-144 (Jan.) 1947

Motor Dysfunction of Biliary Tract: Analytical and Critical Consideration. A. C. Ivy.—p. 1.
*Simple Spontaneous Pneumothorax in Apparently Healthy Individuals: Report of 24 Cases. R. F. Niehaus.—p. 12.
Boeck's Sarcoid (Sarcoidosis). A. Oppenheim and R. S. Pollack.—p. 28.
Pattern Types in Small Intestine. S. M. Friedman.—p. 36.
Peritoneopericardial Diaphragmatic Hernia: Report of Case in Newborn Infant Successfully Corrected by Surgical Operation, with Recovery of Patient. A. K. Wilson, W. R. Rumel and O. L. Ross.—p. 42.
Unusual Venous Returns of Lower Extremities. E. C. Baker.—p. 50.
Osteochondritis Dissecans: Analysis of 42 Cases and Review of the Literature. G. Lavner.—p. 56.
Fractures of Femoral Neck Following Pelvic Irradiation. W. P. Stampfli and H. D. Kerr.—p. 71.
Dysgerminoma of Ovary: Review of 11 Cases of Proved Tumor, with Special Reference to Radiosensitivity. R. D. Moreton and A. U. Desjardins.—p. 84.
*Quantitative Determination of Radium Content of Human Body and of Radon Content of Breath Samples of Prevention and Control of Radium Poisoning in Persons Employed in Radium Industry. V. F. Hess and W. T. McNiff.—p. 91.
Fundamental Principles in Application of Cineroentgenography as Auxiliary Method to Roentgen Diagnosis. J. Moretzsohn de Castro.—p. 103.

Simple Spontaneous Pneumothorax.—A history of physical exertion preceded the onset of spontaneous pneumothorax of only 7 of 24 patients with spontaneous pneumothorax. In 2 instances it followed the throwing of a baseball and snowball respectively and in 3 instances spontaneous pneumothorax followed exertion while in an awkward position. In the uncomplicated cases the acute symptoms usually subsided in a few days, and the time for complete reexpansion of the affected

V 1
194

lung varied from one to eight weeks. Nine patients experienced a recurrent pneumothorax. The present day treatment of recurrent spontaneous pneumothorax is either by the production of a chemical pleuritis or by surgical intervention.

Determination of Radium Content of Human Body to Prevent Radium Poisoning. — An integrating gamma ray method was worked out which allows for determining quantities of radium of the order of 0.1 microgram in the body with a fair degree of accuracy within one hour. Amounts of only 0.03 microgram can be estimated within plus or minus 0.01 microgram. Thus, it is possible to detect incipient radium poisoning before the tolerance limit (set at present as 0.1 microgram) is acquired. The double chamber differential method of determining the radon content of expired air samples from persons employed in the radium industry was improved and simplified for routine work.

American Journal of Tropical Medicine, Baltimore

27:1-78 (Jan.) 1947. **Partial Index**

Tropical Medicine and Challenge of Global War. J. S. Simmons.—p. 1.
Distribution of Exoerythrocytic Parasites and Tissue Reaction Caused by Blood Induced Plasmodium Gallinaceum Infection in Chicks. J. L. Tullis.—p. 21.
Studies on Atabrine (Quinacrine) Suppression of Malaria: III. Epidemiologic Significance of Atabrine Suppression. F. B. Bang and N. G. Hairston.—p. 31.
Transmission of Plasmodium Malariae by Anopheles Maculipennis Freeborni. M. D. Young and R. W. Burgess.—p. 39.
Diagnosis of Schistosoma Mansoni Infections: Note on Use of Rectal Scraper. T. H. Weller.—p. 41.
Results of Certain Studies on Stomach in Schistosomiasis Japonica. E. D. Palmer.—p. 45.
Intradermal and Complement Fixation Reactions Elicited by Various Antigens in Persons Infected with Onchocerca Volvulus. J. Bcziecevich, A. Donovan, L. Mazzotti, F. Diaz A. and E. Padilla.—p. 51.
Intestinal Parasitic Infections in Naval Personnel. E. K. Markell, P. E. Mullinger and D. J. Schneider.—p. 63.
*DDT Dust for Control of Head Lice. F. A. Cowan, T. McGregor and N. M. Randolph.—p. 67.
Treatment of Carrion's Disease with Large Transfusions. C. H. Hodgson.—p. 69.
Evaluation of Surgical Treatment of Recurrent Echinococcic Cysts of Liver Followed by Deep X-Ray Therapy. G. M. Dorrance and J. W. Bransfield.—p. 77.

DDT for Control of Head Lice.—Cowan and his associates say that many requests from school officials and civic organizations were made to the Texas State Department of Health concerning head louse control. Arrangements were made to treat some of the children enrolled in certain schools. The majority of these children were members of large families and lived under crowded conditions. Only volunteers were used, since some children refused treatment. No child having skin abrasions or sores on the scalp was dusted. A dust composed of 10 per cent DDT and 90 per cent pyrophyllite was the insecticide used. The amount of dust applied varied from 2.5 to 5 Gm., the larger quantity being used on girls with long hair. After application of the dust the child was instructed not to wash the hair for one week. At the end of two weeks a second application of dust was made, and a second examination was made to determine the effects of the insecticide on the infestation. A third examination was made at the end of four weeks. At this time only 1 of the 173 treated children had lice, and this child admitted having washed his hair the day after the treatment.

American Practitioner, Philadelphia

1:227-284 (Jan.) 1947

Artificial Insemination: Its Medicolegal Implications, A Symposium: Medical Aspects. J. P. Greenhill.—p. 227.
Legal Aspects. J. F. Wright.—p. 231.
Diagnosis and Treatment of Cancer of Uterus. H. D. Kerr.—p. 242.
Differential Diagnosis of Aortic Stenosis, Pulmonary Stenosis, Patent Ductus Arteriosus and Coarctation of Aorta. W. J. Kerr.—p. 247.
Peripheral Vascular Sclerosis. G. de Takats and E. F. Fowler.—p. 251.
Management of Vivax Malaria in Veteran.—H. Most.—p. 258.
Diagnosis and Management of Peripheral Nerve Injuries. R. A. Groft.—p. 265.
Clinical Physiology of Infectious Diseases of Liver. G. E. Wakerlin.—p. 269.
Maintaining Nitrogen Balance with Amino Acids: Four Adults Maintained by Acid Hydrolyzed Casein Fortified with One per Cent dl-Tryptophan Given Orally. M. L. Soenke, M. G. Horning and E. H. Watson.—p. 276.

Anesthesiology, New York

8:1-112 (Jan.) 1947

Lack of Cerebral Effects of d-Tubocurarine. S. M. Smith, H. O. Brown, J. E. P. Toman and L. S. Goodman.—p. 1.
Immediate Decrease in Blood Pressure Seen at Conclusion of Cyclopropane Anesthesia: "Cyclopropane Shock." R. D. Dripps with technical assistance of Patricia K. Walker.—p. 15.
Anesthesia for Thoracic Surgery: Management in Army General Hospital Overseas. C. L. Burstein and F. A. Duncan Alexander.—p. 36.
Anesthesia: XXIII. The Anesthetic Properties of Three Isomeric Ethers. C. J. Carr, D. B. Farson and J. C. Krantz Jr.—p. 53.
New Endotracheal Instruments. R. D. Sanders.—p. 57.
Problems of Training in and Practice of Anesthesiology in European Theater of Operations. R. M. Tovell.—p. 62.
Pentothal-Curare Mixture. J. W. Baird.—p. 75.
Observations on Literature on Anesthesia. Florence A. McQuillen.—p. 80.

Archives of Dermatology and Syphilology, Chicago

55:1-154 (Jan.) 1947

Progressive Scleroderma of Skin with Cystic Sclerodermal Changes of Lungs. A. Dostrovsky.—p. 1.
Unusual Dermatosis Simulating Lichen Planus and Lichen Corneus Hypertrophicus: Report of 6 Cases. L. M. Nelson.—p. 12.
Ichthyosiform Changes of Skin Associated with Internal Diseases. A. J. Glazebrook and W. Tomaszewski.—p. 28.
Ocular Pemphigus with Scarring of Skin and Mucous Membranes. B. Kanee.—p. 37.
Lipoidosis Cutis et Mucosae: Report of Case. H. Price, W. V. LaRosa and E. B. Settle.—p. 42.
*Topical Treatment with Penicillin Ointment. C. S. Wright and E. R. Gross.—p. 52.
*Agranulocytosis: Report of 12 Cases in Which It Followed Intensive Arsenotherapy for Syphilis. S. Fisher, H. L. Holley and G. Fein.—p. 57.
Tinea Nigra. J. Aroeira Neves and O. G. Costa.—p. 67.
Chronic Latent Oral Moniliasis (Thrush): Report of Case of Twelve Years' Duration in Which Disease was Resistant to Treatment. S. S. Robinson and S. Tasker.—p. 85.
Epidermolysis Bullosa: Recently Described Variant. W. Sachs, A. B. Hyman and Margaret B. Gray.—p. 91.
Benadryl in Dermatologic Therapy. F. W. Lynch.—p. 101.

Topical Treatment with Penicillin Ointment.—Wright and Gross treated a variety of superficial dermatoses with penicillin locally in the form of an ointment consisting of 1,000 Oxford units of calcium penicillin per gram in a base of hydrous wool fat and white petrolatum. Patients were instructed to apply the ointment liberally three to four times daily on the infected areas, and in other instances dressings were employed, which were changed twice daily. All patients were advised to keep the ointment continually refrigerated. Twenty-one of 25 patients with impetigo contagiosa were entirely cured within three days. Only 2 of 23 patients with intertriginous dermatitis of the ears responded to topically applied penicillin ointment. Treatment with penicillin ointment failed completely in infectious eczematoid dermatitis, acne vulgaris, monilia, sycosis vulgaris and in patients with varicose, phagedemic, pyogenic and x-ray ulcers. There was an improvement in the condition of 6 patients with furunculosis and 2 patients with carbunculosis, but no cures were effected in this group. Eight patients with ecthyma responded dramatically to treatment, but negative results were obtained in molluscum contagiosum, dermatophytosis and seborrheic dermatitis. The author concludes that penicillin ointment is of value chiefly in the treatment of impetigo contagiosa and ecthyma.

Agranulocytosis Following Intensive Arsenotherapy for Syphilis.—Fisher and his associates report 11 cases in which agranulocytosis occurred during intensive arsenotherapy for syphilis. One case is reported in which this complication occurred in the course of routine orthodox weekly injections of neoarsphenamine. Fifty per cent of the patients had received no previous therapy for syphilis. The reaction occurred in all cases toward the end of the scheduled course of treatment. Immediate cessation of the administration of arsenicals followed, and therapy with dimercaprol, pentnucleotide and liver extract and, in the more severe cases, blood transfusions were instituted. There were no deaths. The cases reported emphasize the importance of a close survey of all patients receiving arsenicals, with particular observation of the temperature and with routine blood counts.

Archives of Neurology and Psychiatry, Chicago

57:1-136 (Jan.) 1947

*Results of Treatment of Multiple Sclerosis with Dicoumarin. T. J. Putnam, L. V. Chiavacci, H. Hoff and H. G. Weitzen.—p. 1.
Cerebral Blast Syndrome in Combat Soldiers. H. D. Fabing.—p. 14.
*Mechanism of Motion Sickness. G. Morton, A. Cipriani and D. McEachern.—p. 58.
Electroencephalogram and Personality Organization in Obsessive Compulsive Reactions. F. V. Rockwell and D. J. Simons.—p. 71.
Effects of Pitressin Hydration on Electroencephalogram: Paroxysmal Slow Activity in Nonepileptic Patients with Previous Drug Addiction. A. Wikler.—p. 78.
Objective Method for Distinguishing Sleep from Hypnotic Trance. J. B. Dynes.—p. 84.
Circulation of Brain and Face: Determinations of Oxygen and Sugar in Arterial and in Internal and External Jugular Venous Blood. J. Loman and A. Myerson.—p. 94.
Abnormally Large Birth Weights of Psychiatric Patients. H. Barry Jr. —p. 98.

Dicumarol in Multiple Sclerosis.—Putnam and his associates review evidence that sclerotic plaques arise as a result of venular thrombosis. Since Dicumarol (3-3'-methylene-bis-[4-hydroxycoumarin]) seemed to furnish a possible solution for this problem, its administration to patients with multiple sclerosis was begun soon after it became available. It has been administered to a total of 74 patients for periods up to forty-seven months. Patients treated less than six months and those who did not cooperate satisfactorily are disregarded as subjects for study. This leaves 43 for further analysis. Doses of Dicumarol sufficient to raise the prothrombin time to thirty seconds continuously were administered, with constant laboratory control. Twenty-five patients with a remittent form of the disease were adequately treated, without interruption. In this group no fresh symptoms or obvious acute outbreaks occurred. Most of the 16 patients with chronic progressive disease continued in their downward course. The treatment of 2 patients was interrupted; they were free from new symptoms while taking treatment, but both had acute relapses when it was discontinued. In 2 patients large doses of Dicumarol failed to produce the expected increase in prothrombin time, and relapses occurred.

Mechanism of Motion Sickness.—Morton and his associates give a summary of studies on the mechanism of motion sickness, which was produced in human subjects by means of a machine designed to reproduce the movements of a ship at sea. Simple pendulum swings were also effective, although some persons susceptible to one motion did not succumb to the other. Vertical acceleration and deceleration in the long axis of the body with head erect appeared to be the most important element in the production of motion sickness. An increase in the frequency of oscillation resulted in a higher incidence of sickness within the limits of the experiment. There was a definite correlation between history of motion sickness and susceptibility on the machines. Electrocardiographic studies, determinations of sugar, phosphorus and other bases in the blood, studies of gases in the arterial blood and so on revealed no significant changes in connection with motion sickness. It is probable that the most important factor in motion sickness in man is stimulation of the utricles by linear accelerations in the vertical plane of the head.

Archives of Ophthalmology, Chicago

37:1-120 (Jan.) 1947

Ocular Surgery: Random Observations. C. S. O'Brien.—p. 1.
Malignant Melanoma of Limbus and Spontaneous Cyst of Pigmented Layer of Iris in Same Sector: Contribution to Histogenesis of Tumors. A. Loewenstein and J. Foster.—p. 8.
*Atrophy of Optic Nerve Following Hemorrhage. P. Levatin.—p. 18.
Treatment of Lewisite Burns of Eye with Dimercaprol ("BAL"). W. F. Hughes Jr.—p. 25.
*Ocular Changes in Blood Dyscrasias. I. S. Tassman.—p. 42.
Ocular Sporotrichosis: Report of Case. D. M. Gordon.—p. 56.
Positive Contact Ball and Ring Implant for Use After Enucleation. N. L. Cutler.—p. 73.

Atrophy of Optic Nerve After Hemorrhage.—A man aged 34, during a massive hemorrhage from a duodenal ulcer, experienced partial atrophy of the optic nerve in one eye, with later development in the other eye. Repeated determinations of the blood count and the blood pressure revealed a persistent peripheral circulatory failure and such an extreme acute anemia that Levatin considers ischemia the chief etiologic factor.

Ocular Changes in Blood Dyscrasias.—The ocular changes occurring in the blood dyscrasias involve principally the optic disk, retinal vessels and retina in the form of edema, hemorrhages and venous distention. The degree of anemia generally determines the type and extent of the ocular involvement. Exophthalmos is the prominent ocular manifestation in diseases in which the abnormal process occurs in the orbit or involves the bones of the orbit. Tassman describes a case of erythrocytosis with ocular changes which was probably toxic in origin and was of temporary duration. A case of hyperchromic anemia (pernicious anemia) with ocular changes is presented. Four cases of leukemia with ocular changes are summarized. A case of Banti's syndrome with profound anemia and changes in the retinas and both optic nerves is reported.

Arkansas Medical Society Journal, Fort Smith

43:187-208 (Jan.) 1947

Etiology of Essential Hypertension. R. S. Faircloth.—p. 187.
The Field Army and the Profession. G. B. Larson.—p. 191.

43:209-228 (Feb.) 1947

Management of Surgical Lesion of Rectosigmoid. L. P. Good.—p. 209.
Diagnostic Aspects of Ruptured Intervertebral Disks. R. Watson and J. F. Shuffield.—p. 212.

Blood, New York

2:1-110 (Jan.) 1947

Statistical Study of Mortality from Leukemia. M. S. Sacks and I. Seeman.—p. 1.
Treatment of Lymphoblastic Leukemia with Crude Myelokentric Acid. F. R. Miller, P. A. Herbut and H. W. Jones.—p. 15.
Blood Platelets: Rate of Their Utilization in Cat. J. S. Lawrence and W. N. Valentine.—p. 40.
*Folic Acid in Treatment of Pernicious Anemia. L. M. Meyer.—p. 50.
*Hookworm Anemia (Aplastic Anemia in Hookworm Disease). E. Stransky and Florencio N. Quintos.—p. 63.
Observations on Effect of Irradiation in Chronic Acquired Hemolytic Anemia Exhibiting Hemolytic Activity for Transfused Erythrocytes. R. S. Evans and R. T. Duane.—p. 72.
*Congenital Hypoplastic Anemia Associated with Multiple Developmental Defects (Fanconi Syndrome): Report of Case. S. Estren, J. F. Suess and W. Dameshek.—p. 85.

Folic Acid in Pernicious Anemia.—Folic acid in daily doses of 15 to 50 mg. orally or 20 mg. intramuscularly usually produced a submaximal reticulocytosis in patients with pernicious anemia. In 3 patients the hemoglobin and red cells rose to a level of about 12 Gm. and 4.3 million respectively without further rise after three months of therapy. Folic acid in these doses failed to prevent the development or progression of neurologic symptoms indicative of subacute combined sclerosis. In 5 patients folic acid in doses of 5 or 10 mg. orally daily combined with ½ unit of liver extract injected intramuscularly daily produced a reticulocytosis greater than that anticipated from adequate liver extract therapy alone. With combined liver extract and folic acid therapy there was evidence of improvement in the symptoms and signs of subacute combined sclerosis in 3 patients. Folic acid combined with ½ unit of liver extract was found to produce a complete hematologic remission.

Hookworm Anemia.—According to Stransky and Quintos ancylostomiasis is widespread in the Philippines. Their cases were observed in the medical and pediatric wards of the Philippine General Hospital in Manila. They found three types or stages of blood changes. The third of these is an irreversible type, an aplastic anemia. The pathogenesis is obscure, but the authors believe that it is due to bone marrow exhaustion following continuous blood loss in the presence of various factors, including dietary deficiency. The symptomatology and the hematologic and bone marrow findings are described.

Congenital Hypoplastic Anemia Associated with Developmental Defects.—Estren and his associates describe an example of Fanconi's syndrome in a girl aged 11. They believe that this is the first case of this type reported in the American literature. Hypoplastic anemia was associated

with pigmentation of the skin, deafness, congenital heart disease and congenital deformities of the thumbs and forearms. There was no response to liver and iron therapy. Three transfusions of blood totaling 700 cc. were given and had little effect. Because the patient was going progressively downhill, and because splenectomy has occasionally given beneficial effects in hypoplastic anemia, removal of the spleen was undertaken. The patient's convalescence was uneventful. One month postoperatively there were no essential changes in the neutrophil or platelet counts. It seemed that the patient was able to maintain a higher level of erythrocyte count than before the splenectomy. In view of the absence of a history of a similar disorder in either parent or their families, the case must be regarded as a genetic sport due to chance aberration in one or more of the hereditary genes.

Bulletin New York Academy of Medicine, New York

23:1-56 (Jan.) 1947

Tumors of Thyroid. S. Warren.—p. 5.
Tumors of Female Genital Tract. R. W. Te Linde.—p. 10.
Tumors of Breast. G. W. Taylor.—p. 20.
Recent Observations on Dynamics of Pulmonary Circulation. A. Cournand.—p. 27.
Curare and Intensive Physical Therapy in Treatment of Acute Anterior Poliomyelitis. N. S. Ransohoff.—p. 51.

California Medicine, San Francisco

66:1-56 (Jan.) 1947

Most Unphysiologic Period of Life. E. B. Shaw.—p. 1.
Typhus Fever in Second World War. J. C. Snyder.—p. 3.
Immediate Management of Amputations of Hands, Feet and Digits. G. B. O'Connor.—p. 11.
Primary Treatment of Open Wounds of Hand. J. E. Kirkpatrick.—p. 15.
Infection of Hand, with Evolution of Chemotherapy. J. H. Boyes.—p. 18.
Amputations of Hand and Fingers. V. P. Thompson.—p. 20.
Joints of Hand and Fingers—Their Stiffness, Splinting and Surgery. D. R. Pratt.—p. 22.
Use of Blanchard Mechanotherapist in Treating Postoperative Atelectasis. O. L. Huddleston.—p. 25.
Fatal Myocarditis with Complete Heart Block from Diphtheria. R. A. Kocher.—p. 27.
Medical Progress: Recent Progress in Pediatrics. P. Cohen.—p. 30.

Cancer Research, Baltimore

7:1-64 (Jan.) 1947

Desoxyribose Nucleic Acid from Isolated Chromosome Threads in Experimental Epidermal Methylcholanthrene Carcinogenesis in Mice. A. R. Gopal-Ayengar and E. V. Cowdry.—p. 1.
Succinic Dehydrogenase and Cytochrome Osidase in Epidermal Carcinogenesis Induced by Methylcholanthrene in Mice. C. Carruthers and V. Suntzeft.—p. 9.
Growth of Avian Tumors Other than Rous Sarcoma in Anterior Chamber of Guinea Pig Eye. E. W. Shrigley, H. S. N. Greene and F. Duran-Reynals.—p. 15.
Reciprocal Effects of Natural Immune Bodies from Chickens and Ducks on Variants of Sarcoma Virus. F. Duran-Reynals and J. W. King.—p. 21.
Production of Sarcoma with Wheat Germ Oil. P. N. Harris.—p. 26.
Production of Sarcoma in Rats with Light Green SF. P. N. Harris.—p. 35.

Gastroenterology, Baltimore

7:599-730 (Dec.) 1946

*Effect of Transthoracic Vagotomy on Clinical Course of Patients with Peptic Ulcer. J. M. Ruffin, K. S. Grimson and R. C. Smith.—p. 599.
*Insulin Test for Presence of Intact Nerve Fibers After Vagal Operations for Peptic Ulcer. F. Hollander.—p. 607.
*Effectiveness of Parenterally Administered "Enterogastrone" in Prophylaxis of Recurrences of Experimental and Clinical Peptic Ulcer, with Summary of 58 Cases. H. Greengard, A. J. Atkinson, M. I. Grossman and A. C. Ivy.—p. 625.
Intestinal Parasites in Service Personnel in South Pacific, with Special Reference to Incidence and Treatment of Strongyloidiasis. J. H. Willard.—p. 650.
Surgery in Acute Pancreatitis. R. Elman.—p. 656.
Etiology of Cholecystitis. M. E. Rehfuss.—p. 665.

Transthoracic Vagotomy and Peptic Ulcer.—This report by Ruffin and his associates is based on a study of 30 patients at Duke Hospital who have had a transthoracic vagotomy for peptic ulcer. Each patient had a chronic or recurrent ulcer which had failed to respond to previous medical or surgical treatment. One or more operations had been performed on 15 patients. The duration of ulcer symptoms ranged from three to thirty-five years. Since vagotomy, every patient has been relieved of ulcer symptoms and has been able to consume an unrestricted diet without ill effect. The pain was completely relieved immediately after vagotomy. The most constant effect of vagotomy is the reduction or absence of gastric motility. In patients who have had a previous gastroenterostomy, retention and dilatation of the stomach are likely to occur. Decrease in volume and acidity of the gastric secretions usually follow vagotomy. The relief of pain following vagotomy probably is the result of decreased motility rather than a lowering of gastric acidity. The time interval is too short to draw conclusions as to the lasting value of the procedure.

Insulin Test for Intact Nerve Fibers After Vagotomy.—Hollander describes a physiologic test for the presence of uncut vagus nerve fibers in ulcer patients following interruption of vagal stimuli to the stomach. The test is based on the production of a hypoglycemia of 50 mg. per hundred cubic centimeters or lower. Fifteen units of insulin is administered intravenously, and the production of hypoglycemia must always be proved by blood sugar determinations. A fractional gastric analysis is performed to determine whether the resulting vagal stimuli, set up centrally, are able to evoke any secretory response from the stomach. The validity of this procedure is supported by studies on gastric pouch dogs and on patients. A positive response to the insulin test—consisting of a distinct rise in the curve for free acidity of the gastric aspirates, accompanying the production of an adequate hypoglycemia—indicates that some uncut parasympathetic fibers still connect the vagus center in the medulla with the stomach. A negative response is suggestive but not necessarily conclusive proof that all the vagal fibers which pass to the stomach have been interrrupted.

Effectiveness of Enterogastrone in Peptic Ulcer.—Greengard and his associates describe a method for the preparation of an enterogastrone concentrate of uniform potency and suitable for parenteral injection in human subjects. Therapeutic trial on 43 Mann-Williamson dogs and on 58 patients with proved peptic ulcer has demonstrated that the material is probably effective in preventing recurrences during the period of its administration and for an undetermined length of time thereafter. The protection afforded cannot be explained on the basis of the action of enterogastrone in inhibiting gastric secretion, and the true nature of the agent concerned cannot be defined at present.

Illinois Medical Journal, Chicago

90:301-346 (Dec.) 1946

Management of Acute Craniocerebral Trauma. R. Meyers.—p. 310.
Analysis of Hernias and Inguinal Pathology in Young Army Personnel. L. W. Mason.—p. 327.
Arrest of Acute Hemolytic Streptococcal Endocarditis with Penicillin Therapy. H. A. Warren.—p. 331.
Hypertension and Veratrum Viride: Preliminary Study. W. K. Hite.—p. 337.

91:1-60 (Jan.) 1947

Bronchoscopy as Aid in Diagnosis of Pulmonary Disease. P. H. Holinger and A. H. Andrews Jr.—p. 12.
Progress in Neurology and Psychiatry. H. H. Reese.—p. 16.
Treatment of Acute Rheumatic Fever in Young Adults. H. A. Warren.—p. 24.
Acute Cryptogenic Cyanosis in Early Infancy: Clinical Report of Unique Syndrome of Infectious (?) Origin. S. J. Wilkinson.—p. 29.
Endocrinology in Military Service. L. B. Shpiner.—p. 35.
Essentials of Genius. E. Bunta.—p. 40.
Congenital Abnormalities of Mental Patients. H. Stanka.—p. 46.

Industrial Medicine, Chicago

16:1-44 (Jan.) 1947

*Protective Effect of Vaccination Against Epidemic Influenza B in Industrial Plant. W. D. Norwood and R. R. Sachs.—p. 1.
*Refrigeration in Trauma of Extremities. P. Pernworth.—p. 3.
Dental Relations in Industrial Health Services. L. D. Heacock.—p. 5.
Evaluation of Borderline Cardiovascular Abnormalities. J. T. Larkin.—p. 9.
Minor Illness, Short Medical Absenteeism, Lateness and Separation in Mail Order Firm: L. P. Hellman and K. Brodman, with technical assistance of J. Deutschberger.—p. 14.
Hydrofluoric Acid Burn: Case Report. Agnes N. Flack and P. D. Scofield.—p. 17.
Industrial Health Congress. C. O. Sappington.—p. 18.

Vaccination Against Epidemic Influenza B.—Faced with a possible epidemic of influenza and having a small supply of the vaccine, Norwood and Sachs decided to vaccinate several

hundred employees in a war industry. Subcutaneous inoculations of 1 cc. of inactivated influenza virus, types A and B, were given to 366 employees at the onset of an epidemic of influenza B. The incidence in the group vaccinated in time for antibody response was 1.94 per cent. In the comparable group of 4,280 unvaccinated employees the incidence was 8.23 per cent. Loss of time due to sickness was 4.4 times as great in the unvaccinated group as in the group vaccinated early enough for antibody response. The evidence indicates a protective effect of vaccination against epidemic influenza B.

Refrigeration in Trauma of the Extremities.—Pernworth shows that employment of cold for tissue preservation with hope for ultimate functional and morphologic rehabilitation is a therapeutic concept distinct from that of its use as an anesthetic preliminary to amputation. Employing only cracked ice without tourniquet, the author found it impossible to produce undesirable freezing effects regardless of the length of exposure. A man aged 56 who sustained a crushing injury of his left leg halfway between ankle and knee was given 500 cc. of plasma on arrival at the hospital, the leg was surrounded with a 2 inch layer of shaved ice from knee to toes, and it was wrapped in rubber sheeting. Ice was replenished every twenty minutes for two hours until a sterile thermometer inserted deep into the laceration indicated a temperature of 46 F. On the following day small areas of dry gangrene appeared on the dorsum of the foot; although the general condition remained excellent, the prognosis for survival of the leg seemed unfavorable. Nevertheless after thorough antiseptic preparation the tibial fragments were reduced manually, transfixed by thin Steinmann pins above and below the fracture and then incorporated in plaster. Refrigeration, which was resumed, afforded perfect anesthesia for this procedure. Seventy-two hours after the accident slight voluntary movement was present in the toes, but cutaneous gangrenous involvement appeared more extensive. Five days after the injury grayish blue areas of questionable viability had become pink, and active refrigeration was replaced by ice bags surrounding the limb. Within two weeks the hard shell-like plaques of superficial gangrene had separated sufficiently to allow their complete removal, leaving areas of healthy granulation tissue. Subsequent progress was uneventful and terminated in full recovery.

Journal of Aviation Medicine, St. Paul

17:499-612 (Dec.) 1946

Use of Body Armor in Aviation During Wartime. M. C. Grow.—p. 500.
Wounding Effect of High Energy Missiles. M. Halpern and J. B. Hickam.—p. 504.
Internal Injuries Produced by Abrupt Deceleration of Experimental Animals. R. F. Rushmer, E. L. Green and H. D. Kingsley.—p. 511.
Effects of Increased Intrapulmonary Pressure on Dark Adaptation. C. Sheard.—p. 526.
Psychologic Background of "Pilot Error" in Aircraft Accidents. E. C. Kunkle.—p. 533.
Effect of Pressure Breathing on Cutaneous Temperatures of Extremities. J. B. Bateman and C. Sheard.—p. 568.
Global Aviation Medicine in Air Transport Command. M. S. White.—p. 579.
*Passenger Comfort in Commercial Aviation. A. D. Tuttle.—p. 584.
*Variations in Angioscotoma in Response to Prolonged Mild Anoxia. G. M. Smith, C. P. Seitz and K. B. Clark.—p. 590.
Pathologic Lesions Produced by Explosive Decompression. A. Edelmann, W. V. Whitehorn, A. Lein and F. A. Hitchcock.—p. 596.
*Use of Drugs for Prevention of Decompression Sickness. O. L. Williams, W. R. Lyons, E. V. Bridge and S. F. Cook.—p. 602.
Studies on Altitude Decompression Sickness: III. Effects of Denitrogenation. J. S. Gray, S. C. F. Mahady and R. L. Masland.—p. 606.

Passenger Comfort in Aviation.—Tuttle states that the altitude conditioned plane assures low altitude comfort even when flying at high altitudes. This type of plane will eliminate most cases of discomfort currently being encountered aloft. Because of the smoother air prevailing at the higher cruising levels, and the rapid ascents and descents made possible with this new equipment, airsickness rates should fall perceptibly. The same holds true for ear trouble, which should become practically negligible in the absence of appreciable pressure changes on the drum. Because of the passengers' comparatively low exposure to the effects of altitude the need for administration of oxygen should also become extremely rare. The air transportation industry's adoption of the pressure cabin type of airplane reflects the greatest stride forward ever made in passenger comfort aloft.

Angioscotoma in Prolonged Mild Anoxia.—Smith and his associates tested the peripheral blind area (angioscotoma) of 15 subjects five times during a seven and one-half hour exposure to an altitude of 10,000 feet, simulated in a nitrogen dilution chamber. A progressive and statistically significant increase in the size of the scotoma was observed, which became most accentuated at the end of seven and one-half hours. The results are in contrast with the negative data obtained when psychomotor performance is measured. When extraneous motivational factors are eliminated or minimized (and this is probably true of a visual task), an anoxic effect may become progressively evident with prolonged exposure to even a moderate altitude.

Drugs for Prevention of Decompression Sickness.—Williams and his group found that oral premedication with codeine and aspirin, aminophylline and meperidine in an effort to prevent or alleviate the pain of decompression sickness, failed to influence appreciably the performance of 21 subjects exercising at a simulated altitude of 35,000 feet. These investigators think it unlikely that aminophylline and any well known analgesic drug will be of value in the prevention and alleviation of the pain of decompression sickness when taken as a premedication. This does not rule out the possibility that in cases of severe pain occurring at altitude one of the stronger analgesics such as morphine given hypodermically at altitude might be of value.

Journal of Bone & Joint Surgery, Boston

29:1-258 (Jan.) 1947

Education and Certification of Orthopedic Surgeons in the United States. J. A. Key.—p. 1.
*Complications of Fractures of Neck of Femur. H. B. Boyd and I. L. George.—p. 13.
Pathology of Ununited Fractures of Neck of Femur. Mary S. Sherman and D. B. Phemister.—p. 19.
*Complications of Old Fractures of Neck of Femur; Results of Treatment by Vitallium Mold Arthroplasty. M. N. Smith-Petersen, Carroll B. Larson, O. E. Aufranc and W. A. Law.—p. 41.
Newer Pathologic and Physiologic Concepts of Anterior Poliomyelitis and Their Clinical Interpretation. A. Steindler.—p. 59.
Muscle Fibrodystrophy: Syndrome Causing Chronic Physical Disability. R. Bingham.—p. 85.
Pseudarthrosis of Long Bones. I. Blumenfeld.—p. 97.
Fracture Dislocation of Thoracolumbar Spine, with Special Reference to Reduction by Open and Closed Operations. J. K. Stanger.—p. 107.
Osteotomy-Osteoclasis: Method for Correcting Long Bone Deformities. J. R. Moore.—p. 119.
Fracture Dislocation of Ankle with Fixed Displacement of Fibula Behind Tibia. D. M. Bosworth.—p. 130.
Formation and Significance of Vertebral Ankylosis in Tuberculous Spines. J. Puig Guri.—p. 136.
Use of Parallel Grafts and of Two Stage and Three Stage Interlocking Grafts in Treatment of Idiopathic Scoliosis: End Results in 41 Cases. T. Outland and O. Corn.—p. 163.
Vitamin A. Deficiency and Excess in Relation to Skeletal Growth. S. B. Wolbach.—p. 171.
Mobilization of Metacarpophalangeal Joints: Arthroplasty and Capsulotomy. S. B. Fowler.—p. 193.
Preemployment Examinations of Back. S. F. Stewart.—p. 215.

Fractures of Neck of Femur.—Boyd and George present the complications and end results of internal fixation of 300 acute central fractures of the neck of the femur. Smith-Petersen nails were used in 285 of the hips, and Knowles pins were used in 15. On the basis of the results obtained the authors conclude that fracture of the neck of the femur has the following prognosis: mortality, 9.3 per cent; poor end result, 28.1 per cent, including ununited fractures and severe arthritic changes; a fair end result, 19 per cent, and a good end result, 43.6 per cent. It appears that the number of patients with severe arthritic changes in the hip will exceed the number with nonunion. The problem of rehabilitation and treatment of patients with severe degenerative arthritic changes may become more important than the treatment of those with ununited fractures.

Vitallium Mold Arthroplasty in Old Fractures of Neck of Femur.—According to Smith-Petersen and his associates vitallium mold arthroplasty has been performed in 42 cases presenting complications of femoral neck fractures during the past seven and one-half years. Mold arthroplasty consists in

first creating a joint as nearly perfect, mechanically, as possible and then guiding nature's repair by means of an inert mold and carefully supervised exercises. As applied to the treatment of complications of fractures of the femoral neck, the procedure is varied according to the extent of the degenerative changes; four different types of mold arthroplasty have resulted. These include (1) routine mold arthroplasty, (2) modified Whitman reconstruction operation, (3) modified Colonna reconstruction operation and (4) intertrochanteric mold arthroplasty. Routine mold atrophy is indicated in aseptic necrosis of the head, limited in extent and occurring after union of the fractured neck. It consists in reshaping the head and acetabulum so as to create two congruous surfaces; the "crater" representing the necrotic area is excised down to bleeding bone and, in cases of relatively extensive necrosis, the resulting defect is packed with cancellous bone from the iliac crest. The reshaped femoral head is covered with a vitallium mold and replaced in the acetabulum. The authors also describe the other three types of mold arthroplasty and say that the results were satisfactory in more than four fifths of the cases.

Journal of Indust. Hygiene & Toxicology, Baltimore

29:1-58 (Jan.) 1947

Observations on Effects of Diphenyl, o- and p-Aminodiphenyl, o- and p-Nitrodiphenyl and Dihydroxyocatachlorodiphenyl on Experimental Animals. W. B. Deichman, K. V. Kitzmiller, M. Dierker and S. Witherup.—p. 1.

Determination of Acetylene Tetrachloride in Air, Protection Afforded by Gas Mask Canisters Against Acetylene Tetrachloride. J. Goldenson and J. W. Thomas.—p. 14.

Biologic Assay of Inhaled Substances by Dosimetric Method: Retained Median Lethal Dose and Respiratory Response in Unanesthetized, Normal Goats Exposed to Different Concentrations of Phosgene. L. Karel and R. E. Weston.—p. 23.

Adaptation of Dosimetric Method for Use in Smaller Animals: Retained Median Lethal Dose and Respiratory Response in Normal, Unanesthetized, Rhesus Monkeys (Macaca Mulatta) Exposed to Phosgene. R. E. Weston and L. Karel.—p. 29.

Mixed Color Method for Determination of Cadmium in Air and Biologic Samples by Use of Dithizone. F. W. Church.—p. 34.

Evaluation of Minimal Prophylactic Dose of Antirachitic Radiation for Rats with Observations on Antirachitic Wavelength Absorption by Smoky Atmospheres. K. K. Kay and H. M. Barrett.—p. 41.

*Acute and Chronic Toxicity of Methyl Chloride: I. Mortality Resulting from Exposures to Methyl Chloride in Concentrations of 4,000 to 300 Parts per Million. W. W. Smith and W. F. von Oettingen.—p. 47.

*Urinary Fluoride Excretion Among Men Employed in Alkylation Plants Using Hydrogen Fluoride Process. E. J. Largent.—p. 53.

Inhalation Toxicity of Ketene and of Ketene Dimer. H. A. Wooster, C. C. Lushbaugh and C. E. Redemann.—p. 56.

Toxicity of Methyl Chloride.—Smith and von Oettingen present mortality data for several species of animals exposed to methyl chloride in concentrations ranging from 4,000 to 300 parts per million on a schedule of six hours daily per week. If it is assumed that susceptibility of human beings to the lethal effects of methyl chloride is comparable to that of dogs and monkeys, then it is evident that daily exposures to concentrations of 500 parts per million are extremely dangerous even for a period of two weeks or less. At the lower concentrations there appears to be some degree of correlation between development of the central nervous system and toxic effects of methyl chloride. If this is true, human beings may be more susceptible to the toxic effects than any laboratory animals studied. If work in atmospheres contaminated by methyl chloride is unavoidable, the duration of exposure should be cut to a minimum and a maximal interval allowed between exposures. Delayed symptoms and delayed deaths are typical of methyl chloride poisoning.

Urinary Fluoride Excretion Among Men Employed in Alkylation Plants.—Largent points out that in one process for manufacturing high octane gasoline anhydrous hydrogen fluoride is employed as a catalyst. Small leaks in feed lines may give rise to atmospheric contamination in such degree as might cause chronic intoxication of workmen. The average normal urinary excretion of fluorine by man is 0.4 to 1 mg. per day. Largent presents investigation of urinary fluoride content of samples of urine collected from alkylation plant employees. The results of analysis of some 500 samples of urine are given in a table. Only one sample had a fluoride concentration greater than 4 mg. per liter, and in most of the samples the fluoride content was normal or but little above normal.

Journal of Lab. and Clinical Medicine, St. Louis

32:1-108 (Jan.) 1947

Metabolic Function of Pteroylglutamic Acid and Its Hexaglutamyl Conjugate: I. Hematologic and Urinary Excretion Studies on Patients with Macrocytic Anemia. F. H. Bethell, M. C. Meyers, G. A. Andrews and others.—p. 3.

Id.: Urinary Excretion Studies on Normal Persons: Effect of Conjugase Inhibitor. Marian E. Swendseid, O. D. Bird, R. A. Brown and F. H. Bethell.—p. 23.

Effect of Methylated Xanthines on Clotting Time of Blood. N. C. Gilbert, F. Dey and Ruth Trump.—p. 28.

*Penicillin in Beeswax and Peanut Oil, New Preparation Which is Fluid at Room Temperature: Absorption and Therapeutic Use. H. L. Hirsh, H. F. Dowling, J. J. Vivino and Georgine Rotman-Kavka.—p. 34.

Pharmacodynamic Effect in Man of Streptomycin Containing a Histamine-like Factor. W. L. Lewitt and J. J. Curry.—p. 42.

*Histamine Antagonists: VI. Comparative Antihistaminic Activity of Some Ethylenediamine Drugs in Guinea Pig. S. Friedlaender, S. M. Feinberg and A. R. Feinberg.—p. 47.

Unusual Instances of Auricular Flutter. S. F. Aronson and L. N. Katz.—p. 51.

Effect of Oxygen on Malaria: An In Vivo Study in Ducks. R. H. Rigdon and Nona B. Varnadoe.—p. 57.

Determination of Normal Mean Corpuscular Weight (Erythrocyte). Chen-Ting Ch'in.—p. 66.

Bone Marrow of Normal Cats. A. Sawitsky and L. M. Meyer.—p. 70.

Penicillin in Beeswax and Peanut Oil.—Hirsh and his associates employed a preparation of penicillin in beeswax and peanut oil which differs from that of Romansky and Rittman in that it becomes fluid at room temperatures about fifteen minutes after it has been removed from the refrigerator. Twenty-seven patients with various infections were treated with doses varying from 300,000 to 600,000 units once or twice daily. The results were similar to those obtained with the use of other preparations of penicillin in beeswax and oil or with equivalent daily doses of penicillin in aqueous solution. The preparation was found to be easier to administer than the preparations made according to the original Romansky formula.

Histamine Antagonists.—Friedlaender and his associates made a comparative study of 4 synthetic histamine antagonists: benadryl, pyribenzamine, antergan and neoantergan. All compounds afforded some protection to guinea pigs against the fatal effects of intravenous histamine. Five to six times the LD 100 of histamine was necessary to kill all animals protected with 3 mg. per kilogram of benadryl or antergan. The same dose of pyribenzamine was able to protect some animals against as much as thirty-five lethal doses, while neoantergan protected some animals against as much as three times this amount of histamine.

J. Neuropathology & Exper. Neurology, Baltimore

6:1-110 (Jan.) 1947

Multinucleation of Cortical Nerve Cells at Margins of Traumatic Lesions of Human Brain. C. W. Rand and C. B. Courville.—p. 1.

Precocious Puberty with Hypothalamic Tumor (Infundibuloma): Case Report. J. W. Papez and A. Ecker.—p. 15.

Concerning Ganglioglomas of Brain. P. Bailey and Helen Beiser.—p. 24.

Central Nervous System Resistance: II. Lack of Correlation Between Vascularity and Resistance to Circulatory Arrest in Hypothalamic Nuclei. R. G. Grenell and H. Kabat.—p. 35.

*Torulosis of Central Nervous System. G. B. Hassin.—p. 44.

Chronic Progressive Spinocerebellocortical Lipodystrophy Affecting Certain Arterial Supply Areas. O. Marburg and W. Riese.—p. 61.

Agenesis of Corpus Callosum and Associated Malformations. W. R. Kirschbaum.—p. 78.

Labyrinthine Reflexes Following Graded Head Trauma in Rat: Preliminary Report. S. R. Govons.—p. 95.

Congenital Malformation of Brain: Critical Review. F. A. Mettler.—p. 98.

Torulosis of Central Nervous System.—The 2 cases of torula infection of the nervous system reported by Hassin presented a similar clinical but a dissimilar pathologic picture. One patient had an encapsulated tumor the size of a hen's egg which displaced the pons and medulla to the right. The other patient had disseminated involvement of the cerebrospinal system, including the cranial nerves, spinal roots and meninges. In both cases repeated routine examinations of the spinal fluid gave essentially normal results, and the course was chronic in case 1 and acute in case 2. In both cases a diagnosis of brain tumor was made and operations were performed. Aniline dyes (toluidin blue, thionin, methyl blue) bring out in a Torula the presence

of a capsule supplied with numerous spikes, spines or spicules and also of Torulae deprived of capsules as usually seen when hematoxylin-eosin stain is used (so-called naked Torulae). Single Torulae or small torular foci produce no reactive changes, which however are present around large foci or in their vicinity in the form of large infiltrations. Fragments of Torulae are present within the tuft cells of the choroid plexuses—an additional proof that the function of the choroid plexus is excretory and not secretory.

Journal of Neurophysiology, Springfield, Ill.

10:1-86 (Jan.) 1947

Synaptic Conduction to Giant Fibers of Cockroach and Action of Anticholinesterases. K. D. Roeder, Nancy K. Kennedy and Evelyn A. Samson.—p. 1.

Generality of Role of Acetylcholine in Nerve and Muscle Conduction. T. H. Bullock, H. Grundfest, D. Nachmansohn and M. A. Rothenberg.—p. 11.

Giant Nerve Fiber System of Crayfish: Contribution to Comparative Physiology of Synapse. C. A. G. Wiersma.—p. 23.

Topographical Representation of Muscles in Motor Cortex of Monkeys. H. Chang, T. C. Ruch and A. A. Ward Jr.—p. 39.

Effect of Sedatives on Delayed Response in Monkeys Following Removal of Prefrontal Lobes. Marjorie Wade.—p. 57.

Effect of Di-Isopropyl Fluorphosphate on Action Potential and Cholinesterase of Nerve: II. T. H. Bullock, H. Grundfest, D. Nachmansohn and M. A. Rothenberg.—p. 63.

Effects of Potassium on Endplate Potential and Neuromuscular Transmission in Curarized Semitendinosus of Frog. S. M. Walker and Y. Laporte.—p. 79.

Journal of Nutrition, Philadelphia

32:583-700 (Dec.) 1946

Urinary Excretion of Riboflavin by College Women. Wilma Brewer, Thelma Porter, Ruth Ingalls and Margaret A. Ohlson.—p. 583.

Biologic Value of Protein in Relation to Essential Amino Acids Which They Contain: IV. Analysis of Fifteen Protein Foods for Ten Essentials. L. E. Edwards, R. R. Sealock, W. W. O'Donnell and others.—p. 597.

Id.: V. Comparison of Average Effect of Ten Single Amino Acids with Extra Egg Protein as Supplements to an Egg Diet. Estelle E. Hawley, L. E. Edwards, L. C. Clark and J. R. Murlin.—p. 613.

Reproduction and Lactation Studies with Rats Fed Natural Rations. R. R. Spitzer and P. H. Phillips.—p. 631.

Influence of Caloric Intake on Growth Utilization of Dietary Protein. D. K. Bosshardt, Winifred Paul, Kathleen O'Doherty and R. H. Barnes.—p. 641.

Specific Dynamic Action of Diets High in Carbohydrate or Fat. G. C. Ring.—p. 653.

Effect of Proteins Low in Tryptophan on Growth of Chickens and on Laying Hens Receiving Nicotinic Acid-Low Rations. G. M. Briggs, A. C. Groschke and R. J. Lillie.—p. 659.

Utilization of Iron from Different Foods by Normal Young Rats. Orrea Florence Pye and Grace MacLeod.—p. 677.

Journal of Pediatrics, St. Louis

30:1-112 (Jan.) 1947

*Diagnosis and Treatment of Tracheal and Esophageal Obstruction Due to Congenital Vascular Ring. R. H. Sweet, C. W. Findlay Jr. and Gertrud C. Reyershach.—p. 1.

*Penicillin in Treatment of Diphtheria and Diphtheria Carriers. S. Karelitz, L. R. Wasserman and R. E. Moloshok.—p. 18.

Studies on Pertussis Immunization. W. Sako.—p. 29.

Treatment of Allergic Patients with Benadryl: Report of 79 Cases. H. Goldstein.—p. 41.

Treatment of Acute Diarrhea in Cincinnati General Hospital During Years 1944 and 1945. C. Weihl, S. Rapoport and Katharine Dodd.—p. 45.

*Penicillin as Aid in Treatment of Primary Staphylococcus Pneumonia with Empyema. W. S. Davis, Mary E. Hyman and F. D. Ruhstaller.—p. 55.

A-B Blood Groups and Rh-Hr Blood Types in Congenital Athetosis. H. Bakwin and A. S. Wiener.—p. 64.

Follow-Up Study in Rheumatic Subjects Previously Treated with Prophylactic Sulfanilamide. Janet S. Baldwin.—p. 67.

Spotted Fever Treated with Para-Aminobenzoic Acid. W. J. Hendricks and M. Peters.—p. 72.

Postscarlatinal Gangrene with Prolonged Prothrombin Time. B. D. Webb, Elizabeth J. Dubs and Elizabeth Conrad.—p. 76.

Experiences with Japanese Pediatrics. H. A. Agerty.—p. 82.

Tracheal and Esophageal Obstruction Due to Congenital Vascular Ring.—Sweet and his collaborators present detailed reports of 2 cases of the congenital anomaly characterized by a double aortic arch in which they performed operations. The patients were a boy of 3 and a half months and a boy of 9 months. If the posterior and right lateral aspects of the esophagus are indented by the larger persistent right aortic arch, the lesser aortic arch, which is the vessel to be divided, will be found on the left anterolateral aspect of the mediastinum. The visualization of the main aorta descending down the left side of the vertebral column would corroborate this probability. Obviously, under these conditions the vessel to be chosen for ligation will be best reached through the left pleural cavity. Case 1 illustrates this. Case 2 is a mirror image of case 1. Here there were defects of the left lateral and posterior surfaces of the esophagus caused by the larger left aortic arch. The descending aorta was seen by x-ray in the right chest. The anomalous, smaller, right arch could be reached only through the right chest.

Penicillin in Diphtheria and Diphtheria Carriers.—Karelitz and his associates administered penicillin to persons acutely ill with diphtheria and convalescent carriers. The results were encouraging in the treatment of 5 convalescent carriers and 6 patients with faucial diphtheria. The presence of diphtheria among prisoners of war and among American soldiers in the European Theater of Operations afforded the opportunity to investigate these problems. The study was undertaken simultaneously in five hospitals. Patients with faucial diphtheria treated with antitoxin and penicillin, the latter injected intramuscularly every three hours until three consecutive negative nose and throat cultures were obtained daily, were rendered diphtheria negative more rapidly than were the patients who received antitoxin and no penicillin. Carriers of virulent Corynebacterium diphtheriae were likewise rendered free from the bacteria by treatment with penicillin. Penicillin applied locally in the form of nose drops or as nasal spray was not effective in faucial diphtheria but seemed more promising in the treatment of carriers. Penicillin was ineffective in preventing toxic complications of diphtheria but seemed to hasten the clearing and further the development of complications due to pyogenic organisms. Penicillin should not be used as a substitute for diphtheria antitoxin.

Penicillin for Primary Staphylococcic Pneumonia.—Davis and his associates treated 7 children with staphylococcic pneumonia and empyema by giving both intrapleural and intramuscular injections of penicillin. One infant died thirty-six hours after admission. Treatment consisted in the administration of relatively large doses of penicillin intramuscularly and directly into the pleural space, and of moderately large amounts of sulfonamide by mouth. Supportive treatment included blood transfusions and maintenance of a good state of nutrition. Patients should be followed closely by x-ray and fluoroscopy and by repeated physical examination. Surgical drainage should be instituted when indicated.

Journal of Thoracic Surgery, St. Louis

15:373-456 (Dec.) 1946

*Lobectomy and Pneumonectomy in Treatment of Pulmonary Tuberculosis. R. H. Sweet.—p. 373.

Pulmonary Resection in Treatment of Tuberculosis: Present Day Technic and Results. R. H. Overholt, L. Langer, J. T. Szypulski and N. J. Wilson.—p. 384.

Treatment of Chronic Spontaneous Pneumothorax by Lobectomy: Report of Case. L. P. Hoyer and O. T. Clagett.—p. 418.

Role of Pulmonary Plexus in Lung Surgery: Experimental Study. W. H. Bilfeldt-Nicholls and A. Escala Bawden.—p. 422.

Treatment of Thoracic Actinomycosis by Penicillin and Sulfonamide Drugs. H. R. Decker.—p. 430.

Lobectomy and Pneumonectomy in Pulmonary Tuberculosis.—Sweet says that until May 1945 a total of 27 lobectomies and 36 pneumonectomies had been performed at the Massachusetts General Hospital. He says that lobectomy and pneumonectomy can be performed with a considerable degree of safety in pulmonary tuberculosis. The best results followed pneumonectomy in bronchostenosis and thoracoplasty failure and lobectomy in those patients who might otherwise have been treated by means of thoracoplasty. Extirpative surgery has failed to solve the problem of management of patients with enormous cavities which are of the type not responding to collapse therapy. There is no evidence that, except in certain individual cases, lobectomy is superior to thoracoplasty as far as end results are concerned. Because of the practical impossibility of eradicating the entire disease in the majority of patients by extirpation, the most important factor is the resistance of

the patient to the disease. Because pulmonary tuberculosis is not primarily a surgical disease, the hope for future progress lies in the possibility that some medicament may be developed which will overcome the invading organism.

Journal of Urology, Baltimore

57:1-202 (Jan.) 1947. **Partial Index**

New Technic of Perirenal Air Insufflation. F. J. Barquin.—p. 1.
Spinal Cord Injuries: Care of Bladder. G. C. Prather.—p. 15.
Further Observations in Management of Cord Bladder by Transurethral Resection. J. L. Emmett.—p. 29.
Problem of Prostate Gland. G. Carroll.—p. 42.
Modern Conception of Drainage and Irrigation of Urinary Tract. C. L. Deming.—p. 49.
Consideration of Causes of Incontinence, Temporary and Permanent, Following Perineal Prostatectomy. O. Grant and R. Lich Jr.—p. 61.
Surgical Injuries to Urinary Tract. J. U. Reaves.—p. 65.
Management of Injuries to Genitourinary System During War. W. H. Graham.—p. 73.
Present Status of Streptomycin Therapy. S. L. Raines.—p. 79.
Clinical Observations on Nature of Urogenital Gonorrhea. J. H. Dougherty, C. S. DiLucia, A. DiDonna and J. C. Riddler.—p. 84.
Bilateral Pelvic and Ureteral Duplication with Uterine Ectopic Ureter. A. B. Hepler.—p. 94.
*Bilateral Hypernephroma: Case Report. F. L. Senger, J. J. Bottone and G. E. Murray.—p. 106.
*Hypertension: Results of Splanchnicectomy in Patients with Abnormal Pyelograms. R. M. Nesbit and R. T. Plumb.—p. 116.
Carcinoma of Right Ureter Secondary to Neoplasm of Descending Colon. A. H. Kleiman.—p. 120.
Mucinous Adenocarcinoma of Bladder. F. S. Patch and J. E. Pritchard.—p. 126.
Carcinoma of Bladder: Classification of Epithelial Tumors and Study of Effects of External Radiation. F. H. Colby and R. C. Sniffen.—p. 133.
Massive Fatal Air Embolism Following Suprapubic Prostatectomy. M. F. Campbell and J. L. Work.—p. 140.
Twelve Years' Experience with Braasch-Bumpus Resectoscope. B. D. Massey.—p. 149.
Significance of Phosphatase Findings in Carcinoma of Prostate. Helen Q. Woodard and A. L. Dean.—p. 158.
Differential Diagnosis of Tumors of Prostate and Adjoining Areas of Rectum and Bladder by Chemical Analysis. A. L. Dean and Helen Q. Woodard.—p. 172.
Three Cases of Testicular Tumor. J. A. Taylor.—p. 175.

Case of Bilateral Hypernephroma.—Senger and his associates describe a case of bilateral hypernephroma in which the diagnosis was confirmed by tissue study of the tumors during life. This case presents the unusual occurrence of a metastatic lesion appearing in the thyroid gland. This is the first case of bilateral hypernephroma in a female, and the second case in which a biopsy has been obtained to prove tumor in the remaining kidney. The literature has been reviewed and summarized to bring the total number of reported cases to 17.

Splanchnicectomy in Hypertensive Patients with Abnormal Pyelograms.—While reviewing pyelographic data on cases of hypertension, Nesbit and Plumb found 16 abnormal pyelograms. These patients subsequently underwent splanchnicectomy and have been followed for a year or longer. All the patients had supradiaphragmatic removal of thoracic eighth to twelfth ganglions and approximately 20 cm. of the splanchnic nerves. Splanchnicectomy resulted in symptomatic improvement in most of the patients, and corresponding lowering of the elevated blood pressures occurred. All the patients had structural abnormalities of the kidneys that were made evident by pyelography; some were bilateral and some unilateral. Splanchnicectomy appears to have caused no improvement in 1 patient whose renal disease was far advanced; she died two months later of uremia. It appears that gross renal disease does not in itself prevent an effective response to splanchnicectomy, but the operation should not be advocated when the prognosis for life is adversely affected by advanced kidney disease.

Nebraska State Medical Journal, Lincoln

32:1-48 (Jan.) 1947

Medical Problems in Surgical Patient. G. B. Eusterman.—p. 5.
Pre- and Post-Operative Management of Urologic Surgical Patient. C. Tahara and E. Hess.—p. 9.
Functional Indigestion. M. C. Howard.—p. 18.
Some Remarks on Second Stage of Labor with Reference to Use of Forceps. L. A. Calkins.—p. 23.
Early Ambulation in Gynecologic Surgery and Obstetrics. H. E. Anderson and Janet M. Boog.—p. 26.

New England Journal of Medicine, Boston

236:1-44 (Jan. 2) 1947

Coarctation of Aorta: Review and Report of Case. E. D. Maire.—p. 1.
*Hormone Producing Tumor of Adrenal Cortex, with Congenital Absence of Contralateral Adrenal Gland: Report of Case. H. M. Spence and F. G. Thompson Jr.—p. 13.
Acute Appendicitis Occurring During Course of Other Disease. E. S. Hurwitt.—p. 20.
*Asiatic Schistosomiasis: Report of Early Case. L. O. Warren Jr.—p. 24.
Physiologic and Clinical Significance of Plasma Proteins and Protein Metabolites. J. Metcoff and F. J. Stare.—p. 26.
Bulbar Type of Poliomyelitis.—p. 36.
Metastatic Renal Cell Adenocarcinoma (Hypernephroma) of Left Upper Lobe of Lung.—p. 38.

236:45-86 (Jan. 9) 1947

Presentation of Henry Jacob Bigelow Gold Medal: Introductory Remarks and Presentation of Medal. D. Munro.—p. 45.
Surgery of Thyroid Gland. F. H. Lahey.—p. 46.
Visceral Leishmaniasis: Report of Case. S. P. Waud and S. Kruger.—p. 63.
Coexistent Primary Carcinoma of Fallopian Tube and of Breast. Report of Case. J. F. Curran and E. A. Kilroy.—p. 64.
Complete Absence of Lochia Following Delivery: Report of Case. R. J. Heffernan and C. Leavitt.—p. 65.
Physiologic and Clinical Significance of Plasma Proteins and Protein Metabolites (concluded). J. Metcoff and F. J. Stare.—p. 68.
Ulcerative Colitis: Amyloid Degeneration of Kidneys, Liver, Spleen and Adrenal Glands.—p. 75.
Chronic Glomerulonephritis, Inactive.—p. 78.

Hormone Producing Tumor of Adrenal Cortex.—A case of Cushing's syndrome due to an adrenal tumor is reported in which death of acute adrenal insufficiency occurred thirty-six hours after operative removal of the tumor and in which, at necropsy, complete absence of the opposite adrenal gland was found. This is the fourth such case in the literature. From a review of the available literature it is concluded that an increasing number of successful operative removals are being done as the result of better postoperative therapy. The prognosis, however, is still exceedingly grave in the cases associated with Cushing's syndrome, because of the atrophy and insufficiency of the supposedly normal gland.

Asiatic Schistosomiasis.—The case of acute Asiatic schistosomiasis reported by Warren was unique in that an opportunity was afforded to follow the clinical course with repeated sigmoidoscopies and serial roentgenograms from the onset of symptoms to the termination of a course of treatment—a period of sixty days. The characteristic yellowish nodules of the rectosigmoid and upper rectum were shown to have an earlier stage in which they are distinctly red and are smaller and less resistant to the sigmoidoscope than they are in the later course of their development. The diagnostic value of sigmoidoscopy is confirmed. Serial roentgenologic findings are presented that may have represented a reaction of the lung parenchyma to ova or adult worms of Schistosoma japonicum. This case demonstrated the effectiveness of antimony and potassium tartrate (tartar emetic).

236:87-120 (Jan. 16) 1947

*Epidemic Diarrhea of Newborn in Massachusetts: Ten Year Survey. A. D. Rubenstein and G. E. Foley.—p. 87.
Leiomyoma of Jejunum: Report of Case. S. F. Marshall and M. L. Welch.—p. 95.
Arthroplasty of Elbow. W. R. MacAusland.—p. 97.
Effect of Amphetamine Sulfate on Spasmodic Flexion Movements of Foot: Report of Case. J. Loman.—p. 100.
Obstetrics. B. Tenney Jr.—p. 102.
Porphynuric Polyneuritis.—p. 109.
Chordoma of Third Lumbar Vertebra.—p. 112.

Epidemic Diarrhea of the Newborn.—Rubenstein and Foley review 19 outbreaks of epidemic diarrhea of the newborn as reported to the Massachusetts Department of Public Health from 1935 to 1945. Of 768 newborn infants who were exposed during the course of these outbreaks, 258 developed symptoms and 85 died, the case mortality being 33 per cent. The morbidity rates among premature and full term infants were 49 and 21 per cent respectively. The case mortality for premature infants was more than twice that for full term babies. Investigation of nursing technics and methods of formula preparation in nurseries where these outbreaks occurred revealed many inadequacies. Overcrowding, insufficient personnel, general use of a common rectal thermometer and inadequate supervision of formula making

were frequently encountered. Laboratory examinations of so-called sterilizing solutions, including alcohol hand solution and thermometer dips, formulas, nipples and other utensils, showed heavy bacterial contamination. The etiology and the mode of transmission of epidemic diarrhea of the newborn are not known, but supervision of nursery room technics and of formula preparation constitutes a factor in the hospital care of newborn infants that merits greater attention from hospital administrators.

New Jersey Medical Society Journal, Trenton

44:1-38 (Jan.) 1947

Spontaneous Rupture of Spleen: Report of Case. T. H. Andrews.—p. 4.
Early Recognition of Epidemic Encephalitis. F. Frisch.—p. 6.

44:39-86 (Feb.) 1947

Cancer Program in New Jersey: II. Statewide Tissue Diagnostic Service.—p. 41.
Ambulatory Electric Shock Treatment. R. H. Stockfisch.—p. 47.
*Scleroderma Treated with Promin: Report of Case. Virginia Wuerthele. —p. 52.
Acute Osteomyelitis of Cervical Spine with Probable Epidural Infection: Report of Cure with Penicillin Therapy. L. I. Kaplan and H. S. Read.—p. 54.
Hospital Survey and Construction Act. H. A. Cotton Jr.—p. 56.

Promin in Scleroderma.—Wuerthele reports that in 1938 a woman aged 52 began to notice splinter-like, very tender lines under her nails. In 1942 a lump developed on the ulnar surface of the left arm. Numbness, pain and ulcerations of the second and third fingers of both hands occurred. Treatment with Hytakerol (a fraction of irradiated ergosterol) produced some improvement, but in 1946 examination of the hands showed club-like, purple fingers, contracted and painful. The nails were clawed and adherent to the underlying ulcers. Codeine was needed at frequent intervals for relief. Even air currents caused pain. The hands were entirely useless. At this stage promin jelly (a 5 per cent promin in tragacanth), was applied liberally to the hands three times daily and covered with white gloves. Improvement in pain was noticed after two days. The ulcers stopped oozing and began to dry after one week. No further codeine was needed. The patient could touch her fingers to objects without pain. The subungual ulcers healed entirely. The patient was able to dress and feed herself, to sew, make beds, open doors. Even knocking the fingers against a table did not cause pain.

North Carolina Medical Journal, Winston-Salem

8:1-64 (Jan.) 1947

Problems of Biliary Tract Surgery. I. S. Ravdin.—p. 1.
*Revival of Extrapleural Pneumonolysis with Use of New Filling Material, Methyl Methacrylate: Report of 31 Cases. Irene McCain and P. P. McCain.—p. 6.
Definitive Sex Endocrine Therapy in Female. R. A. Ross.—p. 12.
Torsion of Spermatic Cord: Review of 6 Cases. W. M. Coppridge and R. G. Rosser Jr.—p. 14.
Sterilization of Insane and Mentally Deficient in North Carolina. W. P. Richardson and C. J. Gamble.—p. 19.
Some Factors Concerning Sterilization, Based on a Study in Orange County, N. C. G. H. Lawrence.—p. 22.
Aglossia Congenita: Report of Case Without Other Congenital Malformations. R. K. Farrington.—p. 24.
Treatment of Acute Anterior Poliomyelitis. R. B. Lawson.—p. 26.
Importance of pH in Treatment of Diseases of Vagina. C. A. Anderson. —p. 29.

Extrapleural Pneumonolysis.—The McCains point out that extrapleural pneumonolysis has recently been revived with the use of a new filling material, methyl methacrylate, commonly known as "lucite." After many experiments on animals, Wilson began to apply the procedure to patients with pulmonary tuberculosis. Through September 1946 approximately 60 patients have had this operation at Duke Hospital. Thirty-one of these patients, who were from the North Carolina Sanatorium, form the basis of this report. The authors conclude that extrapleural pneumonolysis with the use of methyl methacrylate spheres as packing material appears to offer a reasonably safe means of selective collapse therapy in a limited group of patients with pulmonary tuberculosis for whom no other method of collapse is possible. The operation is not without risk, the most serious complications being incidental to penetration of the pleural space and tuberculous cavities, and to infection. Means of preventing these complications have apparently been determined. The anterior approach under local anesthesia is less shocking to the patient than the posterior thoracoplasty type approach and is to be preferred.

Ohio State Medical Journal, Columbus

43:1-112 (Jan.) 1947

Evaluation of Nutrition in Childhood. C. W. Wyckoff.—p. 33.
Mental Hygiene Program for Ohio: Blue Print for Action. F. F. Tallman.—p. 37.
Place of Physical Medicine in General Practice. W. J. Zeiter.—p. 42.
Cancer of Breast. E. J. McCormick.—p. 48.
Dissecting Aneurysm of Aorta. W. Abramson, D. E. Nolan and G. W. Pedigo Jr.—p. 52.
Electrocardiograph in Industrial Medical Practice: Report Based on 2,000 Electrocardiograms. E. M. Kline and J. H. Hess.—p. 54.

43:113-216 (Feb.) 1947

Epilepsy. E. Haynes and N. P. Dallis.—p. 145.
Practical Concepts in Anesthesia. E. B. Tuohy.—p. 148.
Responsibility in Venereal Disease Control. R. E. Heering.—p. 134.
*Blindness and Brucellosis: Brief Review and Report of Case. L. J. Agin.—p. 159.
Abdominal Pregnancy. H. F. Burkons.—p. 161.
Survey Method of Diagnosing Gastrointestinal Problem Cases. A. A. Hall.—p. 165.
External Otitis. G. S. Lamkin.—p. 167.
Massive Intraperitoneal Hemorrhage Caused by Rupture of Hemorrhagic Corpus Luteum. E. B. Pedlow.—p. 168.

Blindness and Brucellosis.—Agin thinks that ocular damage due to undulant fever is probably more common than has been considered heretofore. He describes the types of ocular damage attributable to brucellosis and a case wherein vision was totally destroyed. Efforts should be made in eye infections to detect or rule out the presence of a systemic invasion by the organism of undulant fever. In the presence of ocular brucellosis general treatment should be under the guidance of an internist and should consist of chemotherapy with sulfonamides, Foshay vaccine, immune serum and nonspecific protein therapy. Locally the usual procedures for uveal tract infection should be adhered to, including heat, atropinization and protection from excess light.

Pennsylvania Medical Journal, Harrisburg

50:345-456 (Jan.) 1947

Present Day Concepts of the Psychoneuroses. F. G. Ebaugh.—p. 361.
Eclectic Approach in Treatment of Neuroses. M. H. Weinberg.—p. 370.
Seeds of Immaturity. E. A. Strecker.—p. 377.
Nontuberculous Pulmonary Calcification and Histoplasmin Sensitivity. R. H. High.—p. 384.
Physical Therapy, Rehabilitation and Occupational Therapy in Surgery. J. M. Deaver.—p. 388.
Adenoidectomy vs. Adenoidotomy. T. F. Furlong Jr.—p. 392.

50:457-552 (Feb.) 1947

Modern State Health Administration. V. A. Getting.—p. 473.
Physician Looks to Improved Public Health Administration in Pennsylvania.—O. E. Turner.—p. 480.
Administrative Problems of State Health Department. J. M. Campbell. —p. 485.
Modern Trends in Management of Uterine Carcinoma. F. L. Payne and G. L. Hoffman.—p. 491.

Review of Gastroenterology, New York

14:1-72 (Jan.) 1947

Gastrointestinal Manifestations of Acute and Chronic Infectious Hepatitis. M. H. Barker and R. B. Capps.—p. 9.
Relapses and Recurrences of Infectious Hepatitis. E. Rappaport and G. Klatskin.—p. 17.
Some Aspects of Stomach Function in Health and Disease. F. L. Apperly.—p. 41.
Duodenal Ulcer—Clinical and Therapeutic Aspects: Follow-Up of 285 Cases. N. W. Chaikin.—p. 49.

14:73-148 (Feb.) 1947

Therapeutic Aspects of Peptic Ulcer. R. Ehrmann.—p. 89.
Surgical Treatment of Duodenal Ulcer. F. W. Bancroft.—p. 98.
*Ambulatory Treatment of Peptic Ulcers with Protein Hydrolysates and Dextri-Maltose. Co Tui.—p. 108.
Histamine in Treatment of Peptic Ulcer. B. M. Bernstein.—p. 129.

Protein Hydrolysates and Dextri-Maltose.—Co Tui reviews observation on the effects of his hyperalimentation treatment in 164 intractable cases of peptic ulcer. He gives protein hydrolysate in doses which furnish 0.6 Gm. of nitrogen per kilogram of body weight, and a carbohydrate, usually salt free dextri-maltose, to make up to 50 calories per kilogram. There

was complete relief of pain from the first feeding on in 48; in 82 the pain was relieved in one or two days and in 18 from two days to one week. Night pains disappeared in the first three days in 35, and in the first five days in 22. The treatment failed in 16, or about 10 per cent, of the patients. To these failures must be added 18 who were unable to tolerate the mixtures. However, since the feeding of separate solutions was instituted, i. e., the dextri-maltose following the hydrolysates, there have been no failures due to intolerance in over 30 consecutive cases.

Southern Medical Journal, Birmingham, Ala.

40:1-114 (Jan.) 1947

*Effect of Transthoracic Vagus Resection on Patients with Peptic Ulcer. R. C. Smith, J. M. Ruffin and G. J. Baylin.—p. 1.
Causes of Failure in Glaucoma Operations. B. F. Payne.—p. 11.
Etiology and Treatment of Cicatricial Stenosis of Larynx and Trachea. F. A. Figi.—p. 17.
Experience in Extraction of Ureteral Calculi with Balkus Looped Catheter. J. J. Nugent.—p. 26.
Plastic Operations in Hysterectomy. O. S. Cofer.—p. 31.
Management of Breast Tumors: Review of 119 Cases. W. C. Jones. —p. 36.
Carcinoma of Breast. K. F. Kesmodel.—p. 43.
Some Recent Experiences with Vitamins and Vitamin Deficiencies. T. D. Spies.—p. 46.
Farm Practices Influencing Incidence of Multiple Sclerosis. J. A. Shield.—p. 55.
Advanced Allergic Emphysema. I. S. Kahn.—p. 62.
World Health Organization. L. L. Williams Jr.—p. 66.
Laboratory Controls in Relation to Penicillin and Streptomycin Therapy. J. A. Kolmer.—p. 72.
Two Year Follow-Up on One Quarter of 1944 Epidemic of Poliomyelitis in Kentucky. C. P. Wood.—p. 76.
Effect of Para-Aminobenzoic Acid in Rickettsial Diseases. N. A. Tierney.—p. 81.

Transthoracic Vagus Resection in Peptic Ulcer.—Smith and his associates report the effect of transthoracic vagus resection on the first 50 patients treated by this method at Duke Hospital. Forty-three of the 50 patients have made a complete clinical recovery to date and have been able to consume a full and unrestricted diet without ill effect. The most constant effect of vagus resection is decreased gastric motility. Gastric retention and dilatation are likely to occur in patients who have not had a previous gastroenterostomy. Vagus resection is usually followed by decrease in volume and acidity in gastric secretion. The relief of pain following vagus resection probably is the result of decreased gastric motility rather than decreased acidity. The time interval is too short to draw conclusions as to the permanent value of the procedure.

Surgery, Gynecology and Obstetrics, Chicago

84:1-106 (Jan.) 1947

*Experimental Study in Wound Healing in Vitamin C Depleted Human Subjects. J. A. Wolfer, C. J. Farmer, W. W. Carroll and D. O. Manshardt.—p. 1.
Excretion and Concentration of Penicillin and Streptomycin in Abnormal Human Biliary Tract: I. Gallbladder. J. Zaslow, V. S. Counseller and F. R. Heilman.—p. 16.
Total Gastrectomy for Carcinoma of Stomach. W. P. Longmire Jr. —p. 21.
*Complications Following Use of Cotton as Suture Material. R. C. Derbyshire.—p. 31.
*Evolution of Adenomas of Large Intestine and Their Relation to Carcinoma. E. B. Helwig.—p. 36.
Surgical Fusion of Vertebral Articular Facets: Technic and Instruments Employed. H. W. Meyerding.—p. 50.
Axillary Approach to Schede Thoracoplasty. A. Lambert.—p. 55.
Hemorrhoidectomy Eliminating Use of Clamp. V. T. Young.—p. 62.
Surgical Correction of Nasal Deformities. L. T. Byars.—p. 65.
Carcinoma of Vulva: Results of Treatment and Effect of Special Factors on Results. F. R. Smith and R. S. Pollack.—p. 78.
Medullary Nailing of Fractures of Long Bones. W. R. MacAusland. —p. 85.
Total Cystectomy by Combined Perineoabdominal Method. S. F. Wilhelm.—p. 90.
Split Thickness Graft—Useful Adjunct in Tube Pedicle Preparation. W. B. Macomber and H. S. Patton.—p. 97.
Ganglioneuroma of Sympathetic Nervous System. A. P. Stout.—p. 101.
Plantar Neuromas, Morton's Toe. W. H. Bickel and M. B. Dockerty. p. 111.
Anterior Transplantation of Posterior Deltoid for Shoulder Palsy and Dislocation in Poliomyelitis. P. H. Harmon.—p. 117.

Wound Healing in Vitamin C Depleted Human Subjects.—Wolfer and his associates had the opportunity to study the effect on wound healing of a prolonged vitamin C deficiency in 9 otherwise normal healthy young men. They found that depletion delays the development of tensile strength in an uncomplicated healing wound from three to five days up to the fourteenth postoperative day. When circumstances for healing are poor, such as in the presence of undue wound tension or diminution in blood supply, this depletion in ascorbic acid is made more evident through gross failure of primary wound healing. The incidence of wound infection under such circumstances suggests the need for ascorbic acid in the tissues for maximum resistance to infection. Human subjects on prolonged ascorbic acid depletion exhibit lack of collagen and reticulum in their healing wounds.

Cotton as Suture Material.—Derbyshire reviews observations on 372 operations in which cotton suture material was employed. There were 17 cases with late complications attributable to the suture material. Of these, 9 were serious and 8 mild. Complications were present more frequently in the earlier than in the later cases in the series, and it is suggested that this may be due to improvement in technic in the later cases as well as to the fact that the use of cotton was finally given up in cases of obvious infection or contamination. While cotton is an excellent suture material, it is not entirely without hazards and has definite limitations.

Adenomas of the Large Intestine and Their Relation to Carcinoma.—This report is based on a study of 1,460 consecutive necropsies in which the entire large intestine was available for examination. Helwig shows that adenomas of the large intestine are true neoplasms. Their incidence increases with age. Adenomas are more common in the white race than in the Negro race. Adenomas are slightly more frequent in men than in women, but single adenomas are more common in women than in men. Multiple adenomas are as common in the fourth decade as in the eighth decade of life in patients who have adenomas. Inflammation, hemorrhage and hemosiderin are commonly observed in the larger adenomas. Adenomas of the large intestine may undergo malignant transition. Both adenoma with malignant transition and carcinoma are more common in the older age groups. Some carcinomas of the large intestine arise directly from the mucous membrane, but the majority develop in adenomas.

84:129-194 (Feb.) 1947

*Carcinoma of Corpus Uteri: End-Results of Treatment in 531 Cases from 1926-1940. H. C. Taylor Jr. and W. F. Becker.—p. 129.
Excretion and Concentration of Penicillin and Streptomycin in Abnormal Human Biliary Tract: II. Hepatic Bile. J. Zaslow, V. S. Counseller and F. R. Heilman.—p. 140.
Effect of Radiation on Vaginal Cells in Cervical Carcinoma: I. Description of Cellular Changes. Ruth M. Graham.—p. 153.
Id.: II. Prognostic Significance. Ruth M. Graham.—p. 166.
Pathologic Physiology of Biliary Drainage: Use of New Type of T-Tube and the Criteria for Its Removal. J. M. McGowan, J. K. Keeley and F. Henderson.—p. 174.
Certain Pelvic Tumors Associated with Ascites and Hydrothorax. M. Calmenson, M. B. Dockerty and J. J. Bianco.—p. 181.
Surgical Substitutions for Losses of External Ear: Simplified Local Flap Method of Reconstruction. J. B. Brown, B. Cannon, C. Lischer, W. B. Davis and A. Moore.—p. 192.
Reconstruction of Esophagus by Skin-Lined Tube. T. W. Stevenson. —p. 197.
Some Observations on Wound Healing: Clinical Study, with Note on Topical Chemotherapy and Secondary Closure. J. M. Farris and T. B. Jones.—p. 203.
Masculinizing Tumors of Ovary: Clinicopathologic Survey with Discussion of Histogenesis and Report of 3 Cases. L. Iverson.—p. 213.
Technic of Thyroidectomy. A. H. Noehren.—p. 239.
*Resection of Clavicle, with Particular Reference to Use of Bone Chips in Periosteal Bed. H. B. Shumacker Jr.—p. 245.

Carcinoma of Corpus Uteri.—The series reviewed by Taylor and Becker includes all histologically proved carcinomas of the corpus uteri in patients admitted to the Memorial Hospital, New York, during the fifteen year period from 1926 to 1940. There were a total of 531. The effect of the gross extent of the disease on the rate of cure is shown by the five year end results in five specified groups. Whereas in the first group, in which the uterus was not enlarged, the rate was 66⅔ per cent, it was only 11.2 per cent in the last group, in which carcinoma extended beyond the uterus. The effect of histologic type is shown by the five year end results in three classifications: adenocarcinoma grades 1 and 2, 47.2 per cent; adenocarcinoma grades 3 and 4, 22.8 per cent; adenoacanthoma, 51.3 per cent. For the patients on whom hysterectomy was

performed a five year cure rate of 51.1 per cent was shown, while in the group of patients treated only with radiation the figure was 36.8 per cent. The group with treatment limited only to radiation contained, however, more patients in a relatively advanced stage of the disease. The question of whether the cure rate from hysterectomy is increased when radiation is given in addition could not be answered.

Resection of Clavicle.—Shumacker shows that the manner in which the bony defect has been handled after resection of the clavicle has varied. The results of subperiosteal resection and discarding of the segment have been excellent in some cases, but in others regeneration has been slow. It seemed desirable to hasten the process of bony regeneration. With this in mind a small group was treated by filling the periosteal bed with bone chips secured from the excised segment of clavicle. Experiences are reported in 4 cases of clavicular resection in which rapid and complete restoration of bony continuity followed replacement in the periosteal bed of such bone chips.

Surgery, St. Louis

21:1-154 (Jan.) 1947

Abdominal Surgery in Evacuation Hospital: Experience with 335 Abdominal Injuries in Campaign in Northern Europe. R. W. Pearson, J. E. Tuhy and C. S. Welch.—p. 1.
*Perforated Gastroduodenal Ulcer. A. La Mont Baritell.—p. 24.
Intussusception of Excluded Distal Ileum with Spontaneous Expulsion per Anum of Sequestrated Intussusceptum. E. O. Finestone.—p. 34.
*Intermittent External Biliary Drainage for Relief of Pruritus in Certain Chronic Disorders of Liver. R. L. Varco.—p. 43.
Splenectomy: Analysis of 38 Cases. J. F. Tanna.—p. 46.
Fatal Hemolytic Reaction Following Transurethral Resection of Prostate Gland: Discussion of Its Prevention and Treatment. C. D. Creevy and E. A. Webb.—p. 56.
Hypermobility of Bones Due to "Overlengthened" Capsular and Ligamentous Tissues: Cause for Recurrent Intra-Articular Effusions. C. J. Sutro.—p. 67.
Vascular Wounds: Report of a Series of 108 Cases Encountered in Forward Evacuation Hospital.—p. 77.
Practical Points in Wolfe Graft Technic. D. W. Macomber and S. K. Wynn.—p. 86.
*Recurrent Parathyroid Adenoma: Case Report. L. B. Burk Jr.—p. 95.
Effects and Drawbacks in Use of Heparin in Retarding Menstruum. D. Weiner and K. Lange, with technical assistance of Florence T. Schein and S. Snyder.—p. 102.
Tantalum Scalp Sutures. C. H. Shelden, R. H. Pudenz and C. S. MacCarty.—p. 106.
New Suction Tube for Chest and Abdominal Operations. F. Gerbode.—p. 109.
Intestinal Obstruction Due to Perforations of Gallbladder: Analysis of 41 Cases of Perforated Gallbladder in 11 of Which There Was Associated Intestinal Obstruction. A. Blain and H. N. Harkins.—p. 110.

Perforated Gastroduodenal Ulcer.—Baritell reviews observations on a group of 88 patients who were operated on for perforated gastric and duodenal ulcers with a mortality rate of 1.1 per cent. A technic of operative treatment, consisting in applying an omental patch to the perforation without any attempt at closure, has been applied to 20 patients with uniform success. It is now the routine at the author's service in all cases and is strongly recommended in any patient in whom there is severe edema or induration about the perforation. Rapid diagnosis and therapy together with chemotherapy and the application of sound surgical principles has resulted in a very low death rate for a disease which heretofore has carried a formidable mortality rate.

Biliary Drainage for Relief of Pruritus.—Varco points out that in certain chronic disorders of the hepatic parenchyma or the intrahepatic biliary system intractable itching is an unpleasant feature. Dihydroergotamine controls the pruritus for only a short while. If the abnormal retention of bile salts is the cause of the pruritus, relief from the itching may be anticipated if it is possible to reduce this concentration in the circulation. Intermittent external biliary drainage suffices to attain and maintain prompt and virtually complete relief from this type of pruritus. Seven operations have been performed on 6 patients without fatality. Circuiting the bile to the outside for short intervals daily has sufficed to keep these persons comfortable. Chronic hepatic disease, either hepatitis or cirrhosis, has been the preoperative diagnosis for all these patients. Pruritus associated with acute hepatitis is so frequently a self-limited disease that surgical procedure for its relief would seem unwarranted.

Recurrent Parathyroid Adenoma.—At operation on a man for a parathyroid adenoma a fragment of the adenoma had become transplanted between the strap muscles of the neck. Two years later the patient returned with manifestations of hyperparathyroidism and a recurrent adenoma at the site of the graft. Burk states that recurrence apparently resulted from proliferation of the transplant. The original tumor was a parathyroid adenoma. It presented no characteristics of malignancy except for penetration of the capsule. In the recurrent tumor, however, some of the cells were less typical, there was no encapsulation, and strands of cells were found between muscle bundles. The pathologists are of the opinion that this tumor should not be diagnosed as carcinoma. While there are mild pleomorphic and hyperchromatic changes in some of the cells, the tumor is still of a well differentiated type.

United States Naval Med. Bulletin, Washington, D. C.

47:1-218 (Jan.-Feb.) 1947. **Partial Index**

Some Future Policies of Medical Department of the Navy. C. A. Swanson.—p. 1.
Notes on Spinal Anesthesia for Interns Using Procaine, or Novocain. A. M. Brooks.—p. 23.
Psychometric Examinations Aboard Destroyer. A. M. Bongiovanni.—p. 27.
Laboratory Diagnosis of Diphtheria. D. D. Albers.—p. 33.
Diabetes Mellitus in a Naval Hospital: Review of 50 Consecutive Cases. J. J. Furlong.—p. 42.
Research in the Naval Hospital. H. M. Hildreth.—p. 52.
Description of Disqualifications of Enlisted Applicants for Submarine Training. C. W. Shilling and N. R. Bartlett.—p. 59.
Epidemic of Prickly Heat on Aircraft Carrier. G. B. Ribble, W. S. Luedemann and S. M. Peabody.—p. 77.
Technic of Local Use of Penicillin in Operative Treatment of Chronically Infected Ingrown Toenails. C. P. Lape.—p. 90.

Wisconsin Medical Journal, Madison

46:1-192 (Jan.) 1947

Procedures for Service Under Wisconsin Veterans Medical Service Agency. T. J. Doran.—p. 31.
Relation of Veterans Administration to WVMSA. W. C. Liefert.—p. 38.
Relation of Wisconsin Department of Veterans Affairs to WVMSA. L. B. Levenick.—p. 42.

46:193-292 (Feb.) 1947

Diphtheritic Heart Disease. M. J. Lustok.—p. 215.
*Allowing Young Children to Set Their Own Pace: Building Human Efficiency. C. A. Aldrich.—p. 225.
Carcinoma of Prostate Gland, a Reevaluation. C. R. Marquardt.—p. 229.

Allowing Young Children to Set Their Own Pace.—Aldrich shows that much of our modern child care is calculated to prevent our youngest generation from "doing its stuff." Infants are hemmed about with strict prohibitions. The author emphasizes the fact that the proposed liberalized or flexible routines, since they are designed to synchronize with infant physiology, make for greater efficiency in the organism. He outlines some of the many ways in which children try to develop through their own mechanisms. He pictures infants as dynamic, purposeful people who, if allowed to progress when they are ready for each step, will become more and more efficient in the art of living.

Yale Journal of Biology and Medicine, New Haven

19:235-392 (Jan.) 1947. **Partial Index**

Problem of Specificity in Growth and Development. P. Weiss.—p. 235.
Three Potentials. H. S. Burr.—p. 311.
Androgen and Anaplasia. C. Huggins.—p. 319.
*Comparative Statistical Studies of Epidemics of Poliomyelitis In and About the City of New Haven, 1916 to 1943. H. A. Wenner.—p. 331.

Epidemics of Poliomyelitis in New Haven.—Wenner made comparative studies on four epidemics of poliomyelitis which occurred in and about the city of New Haven between 1916 and 1943. It was found that a change has occurred in the age incidence of poliomyelitis in New Haven. Prior to 1920 children less than 5 years of age were attacked almost twice as frequently as those aged 5 to 9 and five times as often as older children 10 to 14 years of age. The ratio of cases in these three age groups in 1935 and in 1943 was 1:1:0.7. The seasonal distribution of poliomyelitis during the four epidemics varied slightly. The peak occurred in August or September.

V 1
194

FOREIGN

An asterisk (*) before a title indicates that the article is abstracted below. Single case reports and trials of new drugs are usually omitted.

British Journal of Experimental Pathology, London

27:349-434 (Dec.) 1946

Production of Antibiotics by Fungi: Part II. Production by Fusarium Javanicum and Other Fusaria. H. R. V. Arnstein, A. H. Cook and M. S. Lacey.—p. 349.

Note on a Variant of B. Anthracis Which Fails to Form Heat Resisting Endospores and on Attempts to Immunize Guinea Pigs Against Anthrax Infection with Killed Vaccines Prepared from It. P. B. White. —p. 356.

*Components of Serum Proteins in Infective Hepatitis and in Homologous Serum Jaundice (An Electrophoretic Study). N. H. Martin.—p. 363.

Preparation and Use of Colloidal Gold Sols as Diagnostic Agents. N. F. Maclagan.—p. 369.

Antibiotic from Bacterium Coli. N. G. Heatly and H. W. Florey. —p. 378.

Preservation of Mammary Tumor Agent by Desiccation of Breast Tumor Tissue of Mice. L. Dmochowski.—p. 391.

Immunity to Anthrax: Protective Antigen Present in Cell Free Culture Filtrates. G. P. Gladstone.—p. 394.

Adaptation of "Nitratase" in Washed Suspensions of Bacteria. M. R. Pollock.—p. 419.

Serum Proteins in Infective Hepatitis.—Martin made serial electrophoretic examinations of the serum proteins in 11 patients (8 males and 3 females) with uncomplicated infective hepatitis. He noted depression of the albumin component, with a corresponding rise of gamma globulin. There was disturbance of the alpha and beta globulin, notably between the fourteenth and thirtieth days. It was greatest in 2 patients the course of whose infections was relapsing. A breakdown in the beta complex was noted in certain serums, but it appeared to have no diagnostic significance. The results obtained are in no way peculiar to infective hepatitis. Similar patterns have been obtained in infective mononucleosis, in lupus erythematosus and in other conditions. They are not, therefore, an absolute diagnostic aid. Their value lies in forming a base line for further studies of the administration of protein fractions in the treatment and in assessing the effect of those fractions, if any, on the plasma proteins.

British Journal of Ophthalmology, London

31:1-64 (Jan.) 1947

Removal of Wrong Eye. H. M. Traquair.—p. 8.

Intraocular Foreign Body: Series of 72 Cases in B. L. A. H. B. Stallard.—p. 12.

*"Blue Halos" in Atabrine Workers. Ida Mann.—p. 40.

Subjective "Lightning Streaks." R. F. Moore.—p. 46.

Survey of Results of Lacrimal Stricturotomy. I. Lloyd.—p. 51.

"Blue Halos" in Atabrine Workers.—Mann directs attention to a new industrial disease of the cornea which occurs in workers who handle atabrine (quinacrine) and seems to be caused by an intracellular deposit of an insoluble derivative of atabrine. Its only symptom is the seeing of colored halos (mostly blue) round lights. The prognosis is excellent on removal from contact with atabrine dust.

British Journal of Urology, London

18:165-228 (Dec.) 1946

Gunshot Wounds of Ureter: Three Cases, with Preservation of Kidney in Two. J. Everidge and D. R. Barnes.—p. 166.

Physiologic Variations in Pyelograms Commonly Interpreted as Pathologic: Revised Standard of Normality, with Special Reference to "Cystoid" Theory. R. C. Begg.—p. 176.

Urethrotrigonitis in Relation to Abacterial Pyuria. S. M. Vassallo. —p. 189.

British Medical Journal, London

1:41-78 (Jan. 11) 1947

Value of Penicillin in Surgery. G. A. G. Mitchell.—p. 41.

*Review of Dietetic Factors in Liver Disease: II. Application of Nutritional Principles in Treatment. L. J. Witts.—p. 45.

*Surgical Aspects of Roundworm Disease. F. Barber.—p. 49.

Mesenteric Vascular Occlusion. E. W. Bintcliffe.—p. 50.

Myopathy with Spina Bifida. R. G. Paley.—p. 53.

Dietetic Factors in Liver Disease.—Witts emphasizes that disorders of the liver similar to those produced in experimental animals by dietary deficiency occur in man over wide territories of the world as a result of inadequate food supplies. The incidence of juvenile cirrhosis and primary carcinoma of the liver may well come to be regarded as indexes of nutrition. The problem must now be attacked by social engineering rather than medical science. The number of isolated dietary defects which are known to produce disease is already great, but we are not yet able to permute and combine the various factors so as to discover how they reinforce or neutralize one another. It seems unlikely that fortification with individual principles will be as cheap or as effective as a general improvement of the diet. Our knowledge is more likely to be useful in the selection of those natural foods which can be most expeditiously used to increase the biologic value of the diet.

Surgical Aspects of Roundworm Disease.—Barber says that as a surgeon to the native population of Cyrenaica he repeatedly encountered roundworm infection that simulated surgical conditions. Roundworm infection may become of surgical importance not only by causing mechanical obstruction of the small intestine but by producing inflammatory changes. It is usually difficult to distinguish this variety of inflammation. Correct diagnosis will be facilitated if in regions with prevalent roundworm infection the physician will bear that possibility in mind, using also the laboratory methods for investigation. Surgical treatment will have to consider removal of as many worms as possible from the bowel by "milking" them from adjoining loops toward an incision made over their biggest accumulation. At times the prognosis seems to depend to a considerable extent on the thoroughness with which the worms were removed during the operation.

1:79-124 (Jan. 18) 1947

Endocrines in Gynecology. A. Bourne.—p. 79.

Volvulus of Cecum. R. H. Gardiner.—p. 83.

*Heart in Rheumatoid Arthritis. A. S. Rogen.—p. 87.

Incidence of Yaws and of Venereal Diseases in Lango (Uganda). C. J. Hackett.—p. 88.

Effect of Organic Mercurial Preparations on Diseases of Skin. E. A. J. Byrne.—p. 90.

Heart in Rheumatoid Arthritis.—According to Rogen rheumatic fever and rheumatoid arthritis are generally regarded as distinct diseases which have much in common. The possibility of their having a common etiology has often been discussed. As cardiac lesions are characteristic of rheumatic fever, many workers have sought similar lesions in rheumatoid arthritis. The author records the results of a detailed examination of the cardiovascular system in 33 consecutive cases of rheumatoid arthritis in municipal hospitals in Glasgow. Among these only 1 was found to have a cardiac lesion which might have been attributable to the disease. Another patient was found to have neither histologic nor naked-eye abnormalities of the heart at necropsy.

Journal of Pathology and Bacteriology, Edinburgh

58:325-608 (July) 1946. **Partial Index**

Shape and Motility of Bacteria. A. Pijper.—p. 325.

Preparation and Use of Simple Culture Medium for Leptospira. R. D. Stuart.—p. 343.

Bactericidal Power of Blood for Infecting Organism in Bacteremia. O. Khairat.—p. 359.

*Morphologic Changes in Red Cells in Relation to Severe Burns. A. Brown.—p. 367.

Standardization of Scrub Typhus Vaccine. A. Henderson-Begg and F. Fulton.—p. 381.

Microbic Dissociation in C. Diphtheriae by Production of Daughter Colonies. H. S. Carter.—p. 391.

Morphologic Equivalents in Polyarthritis Rheumatica, Periarteritis Nodosa ,Transient Eosinophilic Infiltration of Lung and Other Allergic Syndromes. H. Bergstrand.—p. 399.

Pathologic Changes Induced by Lewisite and Allied Compounds. G. R. Cameron, H. M. Carleton and R. H. D. Short.—p. 411.

Account of Pathology of Some Cases of Clostridia Welchi Infection. A. D. T. Govan.—p. 423.

Pathology of Simple Gastritis. H. A. Magnus.—p. 431.

Inhibition of Various Clostridia by Penicillin in Human Serum. R. W. N. L. Ross.—p. 441.

Absorption of War Gases by Nose. G. R. Cameron, J. H. Gaddum and R. H. D. Short.—p. 449.

Lower Accessory Pulmonary Artery with Intralobar Sequestration of Lung: Report of 7 Cases. D. M. Pryce.—p. 457.

Monocytic Leukemoid Reaction Associated with Tuberculosis and Mediastinal Teratoma. Anne Gibson.—p. 469.

Effect of Penicillin on Tubercle Bacillus. C. N. Hand.—p. 495.

Disseminated Parenchymatous Ossification in Lungs in Association with Mitral Stenosis. A. Elkeles and L. E. Glynn.—p. 517.

Red Cell Changes in Severe Burns.—Investigation of the morphologic changes occurring in the red cells of 3 severely burned patients revealed that fragmentation of the red cells and microspherocytosis occur within a few hours of the injury.

Microspherocytosis was seen in stained films and was shown to be associated with an increase in the mean corpuscular average thickness. Fragmentation of the red cells was most obvious in the most severely burned patient and was associated with hemoglobinemia and hemoglobinuria. These morphologic changes can be attributed to the direct action of heat on the cells. The maximum effect is immediate fragmentation and destruction. If the damage is less severe, microspherocytosis is produced and the cells are unduly susceptible to the physiologic trauma of the circulation.

Journal of Physiology, Cambridge

105:299-398 (Jan.) 1947. **Partial Index**

Rate and Site of Acetate Metabolism in Body. D. H. Smyth.—p. 299.
Color Sensitivity of Retina Within Central Fovea of Man. L. C. Thomson and W. D. Wright.—p. 316.
Ferricyanide Method of Blood-Gas Analysis. F. C. Courtice and C. G. Douglas.—p. 345.
Experiments on Liver Sympathin. J. H. Gaddum and L. G. Goodwin.—p. 357.
Action of Chemical Vesicants on Cholinesterase. R. H. S. Thompson.—p. 370.
*Vitamin A and Bone Growth: Reversibility of Vitamin A Deficiency Changes. E. Mellanby.—p. 382.

Vitamin A and Bone Growth.—Mellanby points out that a deficiency of vitamin A in the diet of growing animals causes widespread nerve degeneration. A cause of this degeneration was suggested when the examination of serial sections of the labyrinth and its capsule revealed that vitamin A deficiency results in a large bone hypertrophy which injures or destroys the nerve fibers and the cells of the spiral ganglion by pressing on the eighth nerve. The chief point of interest in this publication is the study of the reparative or recovery stage of bone growth, especially of the cranial bones, when vitamin A is restored to an animal after a period of deficiency. The addition of vitamin A to the diet of an A-deficient animal during growth brings about a return of osteoclastic and osteoblastic activity to the surfaces where it is normally found. Although vitamin A deficiency causes a general thickening and dysplasia of bone by its effect on osteoclasts and osteoblasts, the method of producing this abnormal state varies, as is shown in the three regions discussed, namely the basi-occipital, the periosteal bone covering the labyrinth, and the sphenoid bone in relation to the optic foramen. The recovery changes on adding vitamin A are also different in different cases. The altered shape of bones adjacent to the nervous system may destroy cranial and spinal nerves and exert other harmful effects, but the recovery changes in dysplastic bone on the addition of vitamin A to the diet take place independently of the condition of the adjacent nerve or nervous tissue.

Lancet, London

1:49-88 (Jan. 11) 1947

Rest versus Activity in Treatment of Fracture. G. Perkins.—p. 49.
*Acute Porphyria. J. Jørgensen and T. K. With.—p. 54.
*Rubella as Cause of Congenital Deafness in England. E. Clayton-Jones.—p. 56.
Duct Papillomata of Breast. C. Wakeley.—p. 62.
*Penicillin in Agranulocytic Angina: Report of Case. I. A. R. Mackenzie.—p. 63.
Staphylococcal Food Poisoning by Meat-Pie Jelly. F. A. Belam.—p. 64.

Acute Porphyria.—Jørgensen and With review recent progress in the knowledge of porphyria and emphasize that there is evidence that barbiturates exert a harmful effect on patients with porphyria, even when it is latent. Two cases illustrating this effect are reported.

Rubella as Cause of Congenital Deafness.—Clayton-Jones says that an inquiry has been made in schools for the deaf in England to ascertain whether the association established in Australia between maternal rubella in the first three months of pregnancy and congenital defects, mainly cataract, deaf-mutism and heart lesions, could be confirmed. At one school with 18 children 8 mothers gave a definite and 1 a probable history of rubella in the second to fourth months of pregnancy. In three larger schools a maternal history of rubella in pregnancy was obtained in 11 out of 123 children. Deaf children with a maternal history of rubella were found to have a bilateral, incomplete, inner ear deafness usually fairly uniform throughout the frequency range. Difficulty in feeding during infancy was commonly reported, and examination showed a tendency to deformity of the jaw, pigeon chest and atonic musculature; no cataract or heart lesion was detected. Notifications at Manchester show that the rubella epidemic of 1940 was peculiar in involving an unusually high proportion of young women. An attempt should be made to protect pregnant women against rubella in the first four months of pregnancy.

Penicillin in Agranulocytic Angina.—Mackenzie observed a prisoner of war in whom the appearance of the blood film, considered in conjunction with the profound leukopenia, suggested an aleukemic leukemia of the monocytic type; in view of the throat condition, however, the diagnosis of agranulocytosis was preferred. The question then arose whether it was wiser to attempt to raise the polymorphonuclear leukocyte count with pentnucleotide or to attack the infection with penicillin. The patient's rapid improvement in both physical condition and leukocyte count seems to show that the latter course was correct.

Medical Journal of Australia, Sydney

2:889-920 (Dec. 28) 1946

*Final Observations on Congenital Defects in Infants Following Infectious Diseases During Pregnancy, with Special Reference to Rubella. C. Swan, A. L. Tostevin and G. H. B. Black.—p. 889.

1:1-32 (Jan. 4) 1947

Australasian Anophelines as Vectors of Malaria. I. M. Mackerras.—p. 1.
Inguinal Hernia. J. C. B. Allen.—p. 8.

Defects in Infants Following Infectious Diseases During Pregnancy.—Swan and his associates say that of 61 children comprising their first and second series they were able to reexamine 49. The most important result of the resurvey was the detection of 4 further cases of deaf-mutism. In 1 patient spontaneous absorption of a cataractous lens had occurred. Many of the children were retarded in their physical development. A fourth series consisting of 25 cases was studied. In 17 instances (1 doubtful) the mother had contracted rubella in pregnancy. In 1 case the mother had suffered also from chickenpox. Fifteen of the babies born subsequently exhibited congenital defects. The abnormalities included cataract, deaf-mutism, heart disease, microcephaly, umbilical hernia, bifid uvula, mental deficiency, epilepsy, speech defect and concomitant strabismus. Thirteen of the 15 mothers had suffered from German measles during the first four months of pregnancy. Of 2 infants that were free from congenital malformations, one mother had suffered from the disease in the first month and the other in the seventh month of gestation.

Transactions Roy. Soc. Trop. Med. and Hyg., London

40:205-356 (Dec.) 1946

Atebrin Susceptibility of Aitaipe-Wewak Strains of P. Falciparum and P. Vivax. N. H. Fairley.—p. 229.
*Control of Plague by Means of Live Avirulent Plague Vaccine in Southern Africa (1941-1944). E. Grasset.—p. 275.
Transmission of Dengue Fever by Aedes (Stegomyia) Scutellaris Walk. in New Guinea. I. M. Mackerras.—p. 295.
Etiology of Desert Sore. S. T. Anning.—p. 313.
Heterophile Antibodies in Trypanosomiasis. A. Henderson-Begg.—p. 331.
Tsetse Fly Repellents. G. M. Findlay, J. Hardwicke and A. J. Phelps.—p. 341.
Growth of Protozoa in Tissue Culture: III. Trypanosoma Cruzi. F. Hawking.—p. 345.

Control of Plague by Live Vaccine.—Grasset reviews observations made in southern Africa on antiplague immunization with live avirulent vaccine in fourteen plague outbreaks between 1941 and 1944. He stresses the harmlessness of the method, which was evidenced by the absence of untoward reactions in over 40,000 doses used in preventive mass immunizations of European and native populations. The vaccinal reactions were mild. A high degree of specific protection developed rapidly following immunization. A total of 15 cases with 7 deaths were observed among over 24,000 persons immunized during nine bubonic and septicemic, three pneumonic and two mixed bubonic pneumonic and septicemic outbreaks. Protection derived from immunization begins to be effective from the fifth day after inoculation, reaching full benefit toward the tenth day after inoculation. The author concludes that a single live avirulent plague inoculation (1,000 million organisms) with usual antiplague measures realizes a safe, easily applicable, well accepted and efficient mass plague control method in the epidemiologic field conditions existing in South Africa.

Presse Médicale, Paris

54:881-892 (Dec. 28) 1946. **Partial Index**

Penicillin Therapy and Obstetric Surgery. L. Portes, M. Mayer and A. Granjon.—p. 881.
Pleuropulmonary and Pseudoperitoneal Form of Epidemic Myalgia. R. Bogaert.—p. 881.
Utilization of Animal Plasma or Serum in Human Subjects. Georgette Cordier and J. Demirleau.—p. 883.
*Treatment of Chronic Rheumatism with Organic Salts of Copper. J. Forestier and A. Certonciny.—p. 884.

Organic Salts of Copper in Chronic Rheumatism.—Forestier and Certonciny used a cupro-allyl-thio-urea-benzoate of sodium which contains 19 per cent of copper in 50 cases of various forms of rheumatism. The preparation is administered twice weekly by intravenous injection. At each injection 0.25 Gm. is usually administered, but recently 0.5 Gm. has been given. The total dose in one series of injections varies between 2.5 and 5 Gm. The intervals between series are from one to three months. The intravenous mode of administration is painless, whereas the intramuscular injection is extremely painful. The substance does not exert toxic effects on the liver or kidney or on the blood or the hemopoietic organs or the skin or mucous membranes. Fatigue and loss of weight were observed in some patients at the end of the series but disappeared rapidly. As regards the action of the organic copper compound, the authors say that it acts quicker and better than do the gold salts.

Schweizerische medizinische Wochenschrift, Basel

76:1273-1300 (Dec. 14) 1946. **Partial Index**

Roentgenologic Aspects of Pancreatic Disorders. M. Lüdin.—p. 1273.
*Diphtheria Carriers: Their Frequency and Treatment. H. Reber.—p. 1275.
Therapy of Agranulocytosis in Tonsillogenic Infection. H. Cadotsch.—p. 1279.

Diphtheria Carriers.—Reber shows that in searching for carriers of diphtheria bacilli the culture medium on tellurite will be a favorable substitute for mediums previously used. In order to detect as many carriers as possible in an isolated community a minimum of three samples must be collected at intervals of two days. If this is done an average of 6 per cent of carriers are detected in an environment that is free from diphtheria. In children between 3 and 6 years of age the number of carriers is double the average; after that it decreases with age, but in every age group some are found. If an epidemic of diphtheria is feared, it is necessary to treat all persons harboring bacilli with the morphologic characteristics of diphtheria bacilli, since there is no reliable and rapid criterion of pathogenicity. On the basis of experiences with various therapeutic methods, the author says that the local application of penicillin is most effective and represents the method of choice in bacillus carriers. Medical treatment has permitted a considerable reduction of the number of tonsillectomies, this operation being performed only when the general condition of the patient requires it, and when the tonsils constitute a focus of infection.

Arch. Soc. Argent. Anat. N. y Pat., Buenos Aires

8:5-162 (Oct.) 1946. **Partial Index**

*Mammary Sarcoma in Women. D. Brachetto-Brian.—p. 35.

Mammary Sarcoma in Women.—Brachetto-Brian performed 10,000 pathologic examinations during a period of sixteen years in the Durand and Ramos Mejia Hospital. He found 350 mammary tumors, of which 212 were malignant. Among the 212 malignant ones there were 207 carcinomas and 5 sarcomas, namely a reticulum cell sarcoma with giant cell formation, primary in the breast, in which its rapid growth led to the diagnosis of acute cancer; 1 fibroblastic sarcoma of seven months' duration in a woman aged 30, situated immediately behind the gland, which is included because it was impossible to establish its independence from the gland; 2 cases of secondary adenofibrosarcoma, 1 of them recurrent, both of which had arisen in a "cystosarcoma phyllodes" (Müller) or "giant intracanalicular myxoma of the breast" (Lee and Pack), and a secondary adenofibrosarcoma arising in a fibroadenoma.

Revista de Gastroenterol. de Mexico

11:1-44 (Jan.-Feb.) 1946. **Partial Index**

*Abdominovenous Direct Transfusion of Ascitic Liquid in Hepatosplenic Cirrhosis. A. Acevedo Olvera.—p. 27.

Transfusion of Ascitic Liquid in Ascitic Cirrhosis.—Acevedo Olvera based this treatment on the facts that (1) in patients with ascitic cirrhosis of the Laënnec or Banti type the plasma proteins are low, whereas the proteins in the ascitic liquid are high, (2) proteins favor liver function and (3) they are absorbable by the peritoneum. He administered the ascitic liquid to 18 patients with that type of ascites. The liquid was injected directly from the abdomen intravenously by means of an apparatus for transfusion without any modification of the ascitic liquid but just as it was found in "free" ascites. The total quantity for an injection was from no definite figure up to 1,000 cc. The total amount administered varied from 2 to 10 liters. In 4 of the 18 patients the treatment began very late in the course of the disease. Five patients were cured; 3 are still under treatment. In the rest great improvement was noted. One of the patients had brucellosis as the cause of his Banti's syndrome. In general the treatment results in improving the opportunity of the patient for a more favorable reaction to the proper medical, biologic, vitamin and physical therapy in modern use as well as to the proper diet. The article is a preliminary report. The author concludes that the treatment is harmless. It improves the liver functions, is economical, is reliable and is indicated only in "free" ascites due to Laënnec's cirrhosis or Banti's syndrome.

Acta Pathol. & Microbiol. Scandinav., Copenhagen

23:293-378 (No. 4) 1946. **Partial Index**

*Method for Production of High Titer Tetanus Serum. A. W. Buer.—p. 293.
Observations on Salmonella Enteritidis Var. Danysz and Salmonella Enteritidis Var. Chaco in Man. M. Kristensen.—p. 299.
Anterior Pituitary and Parathyroids in Hypercalcemia: Comparison Between Hyperparathyroidism and Myelomatosis, with 2 Reported Cases of the Latter Disease. J. Mellgren and G. Lundh.—p. 330.
Sensitivity of Meningococci to Penicillin and Sulfathiazole in Vitro. A. Lundsteen.—p. 372.

Production of High Titer Tetanus Serum.—In producing tetanus serum Buer has tried a modification of Ramon's method of inoculation. Ramon injects an emulsion of olive oil, lanolin and tetanus toxin or anatoxin, which causes an inflammation infiltrate. The modification consists in the injection of the toxin into an already existing inflammation infiltrate three or four days after the injections of the aforenamed emulsion. By this means the titer has been doubled and multiplied. Titers of up to between 4,000 and 4,800 international units per cubic centimeter have been obtained.

Nederlandsch Tijdschrift v. Geneeskunde, Amsterdam

90:1767-1826 (Nov. 30) 1946. **Partial Index**

Creatinine Elimination in Urine of Patients with Hunger Edema. W. Radsma.—p. 1775.
*Therapy of Migraine. H. K. G. Bartstra.—p. 1786.
*Adenoma of Islands of Langerhans in Pregnancy. A. W. M. Pompen, C. A. L. Jansen and J. Dhont.—p. 1791.

Therapy of Migraine.—Bartstra says that patients subject to migraine experience great relief if given from 5 to 10 drops of dihydroergotamine three times daily. Equally favorable results were obtained by giving to women tablets containing an extract prepared from fresh testis tissues and to men tablets containing an extract of ovarian tissue. Treatment is begun by giving three times daily two tablets of the testicular or ovarian preparations. It is not known what factor exerts this favorable effect, since the sex hormone isolated from testis tissues exerts no particular influence on migraine. Thus another substance must be responsible. The frequency of the attacks decreases and the unpleasant sensations between the attacks are also favorably influenced.

Adenoma of Islands of Langerhans During Pregnancy.—Pompen and his associates present the history of a woman aged 35 who had hyperinsulinism as the result of an adenoma of the islands of Langerhans. She passed through two preg-

nancies after she developed the hyperinsulinism and was free from attacks of hyperinsulinism during the first of these pregnancies and during the second half of the second pregnancy. The attacks returned on the thirteenth and ninth days respectively after childbirth. It is suggested that the glycotropic or anti-insulin factor may play a part. Recent investigations indicate that this activity might be ascribed also to the corticotropic hormone. The hypophysis is thought to produce this substance in abundant quantities in the course of pregnancy.

Acta Oto-Laryngologica, Stockholm

34:521-620 (Nov.-Dec.) 1946. **Partial Index**

Peritonsillar Abscess and Mediastinitis. N. G. Richtnér.—p. 521.
Connection Between Osteomyelitis of Cranial Bones and Inflammatory Processes in Nose and Its Accessory Sinuses. A. de Kleyn.—p. 534.
*Etiology and Treatment of What Is Known as Rheumatic Facial Paralysis. E. Bergström.—541.
*Diseases of Ear Due to Louse Borne Typhus: (Experiences with 800 Cases of Typhus). J. Mérei.—p. 572.
Some Remarks About Physiopathology of Vestibular Apparatus. E. Wodak.—p. 593.
Experimental Histologic Studies on Labyrinth: X. Supplementary Remarks Concerning the Phenomena of Compression Observed on Intravital and Postmortem Fixation. S. H. Mygind and D. Dedering. —p. 609.

Rheumatic Facial Paralysis.—Bergström says that until recently the treatment of rheumatic facial paralysis, commonly called Bell's palsy, has consisted almost exclusively of simple physical treatments. However, since paresis and contracture or even total paralysis may develop after this conservative treatment, surgery is now being resorted to. A woman aged 35, who had had facial paralysis of the peripheral type on the right side for fifteen years, was cured by surgical intervention. In the course of a decompression operation a section of the facial canal was found to be contracted, which condition is assumed to have contributed to the paralysis. The author thinks that, since spontaneous healing takes place in most cases, operation should not be considered until four months has elapsed without signs of improvement.

Ear Symptoms in Louse Borne Typhus.—Observations on 800 cases of typhus revealed to Mérei that impairment of hearing occurred in from 60 to 65 per cent of the cases, usually in the early stage of the disease. Gradual recovery began after three weeks. As regards the vestibular system, the author says that ataxia with vertigo appeared in about 40 per cent of the cases. The vertigo was not due to fever. Past pointing, ataxia and spontaneous falling often were present up to the end of convalescence. Nystagmus appeared in from 6 to 8 per cent of the patients. The symptoms indicating involvement of the vestibular apparatus appear so early that they can be accepted as a reliable diagnostic sign for typhus.

Nordisk Medicin, Gothenburg

31:1719-1794 (Aug. 9) 1946. **Partial Index**

Fatal Pulmonary Embolism. H. Zilliacus.—p. 1719.
Treatment of Scabies. B. Heilesen and P. V. Marcussen.—p. 1722.
Health Control in Adults. E. Møller.—p. 1723.

Hospitalstidende

Diabetes Mellitus in Infants. E. Henriksen.—p. 1727.

Duodecim

Cancer of Breast and Pregnancy. K. Kettunen.—p. 1747.
Waterhouse-Friderichsen Syndrome. E. Klemola and R. Tammilehto. p. 1750.
Penicillin Therapy in Case of Simultaneous Gonorrhea and Primary Syphilis. T. Putkonen.—p. 1753.

Norsk Magasin for Lægevidenskapen

*Relation of Renal Tuberculosis to Primary Tuberculous Infection. H. J. Ustvedt.—p. 1755.

Hygiea

Nucleotide Metabolism of Dentine Cells Under Normal Conditions and in Vitamin C Deficiency. A. Wilton and B. Thorell.—p. 1784.

Relation of Renal Tuberculosis to Primary Tuberculous Infection.—Ustvedt states that in over two thirds of 292 cases of renal tuberculosis treated during the last ten years the time between the primary tuberculous infection and the appearance of the renal tuberculosis was more than five years. Renal tuberculosis only occasionally represents disease of the isolated organ; it is more often a link in tuberculosis as a general disease. It manifests itself much later in the course of the tuberculous infection than most other tuberculous manifestations, is often preceded by one or more other localizations of tuberculosis and is not infrequently followed by other tuberculous involvement. It may be present a long time before clinical symptoms appear, and moderate changes may be stationary for years. Much of the pathogenesis of renal tuberculosis is uncertain. Various facts support the American and French conception of bilateral start of the disease with multiple foci localized in the cortex.

31:1795-1866 (Aug. 16) 1946. **Partial Index**

Vitamin Problems. J. Hagtvet.—p. 1795.
Vasodilating Agents. A. Harrestrup Andersen.—p. 1802.
Follow-Up of Male Diabetic Patients. D. Elstad.—p. 1807.

Hospitalstidende

Influence of Experimental Alcohol Intoxication on Deposit and Resorption of Vitamin D. H. Behrnts Jensen and O. Wanscher.—p. 1811.

Hygiea

*Congenital Hyperplasia of Islets of Langerhans with Increase in B Cells in Fetuses of Diabetic Mothers. G. T. Hultquist, Inga Lindgren and J. B. Galgaard.—p. 1841.

Congenital Hyperplasia of Islets of Langerhans in Fetuses of Diabetic Mothers.—Hultquist and his associates report 4 cases of pregnancy in diabetic mothers with death of the fetus immediately before or during delivery. In 1 instance the mother's carbohydrate tolerance improved during the last months of the pregnancy; in all cases the blood sugar rose after delivery or intrauterine death of the fetus. Microscopic examination of 3 of the fetuses showed hyperplasia of the islets of Langerhans, and study by silver impregnation revealed increase in the B cells in proportion to the number of A cells. There was fatty degeneration of the liver and less severe degeneration of the kidneys, together with increased glycogen content. The adrenals were hyperplastic and in 2 cases hyperemic.

31:1867-1930 (Aug. 23) 1946. **Partial Index**

Slight and Grave Instability in Lumbar Column in Disk Degeneration. F. Knutsson.—p. 1875.

Hospitalstidende

Takata-Ara Reaction as Liver Function Test and Simple Titration as Substitute. T. Grinsted.—p. 1879.
Postoperative Iodine Treatment in Thyrotoxicosis. Anne Marie Gade. —p. 1883.
Podophyllin Treatment of Condylomata Acuminata. D. Trolle.—p. 1886.

Norsk Magasin for Lægevidenskapen

*Perforating Gastric and Duodenal Ulcer in Vestfold District Hospital 1936-1944. R. Saxholm.—p. 1889.
Treatment of Tendon Lesions of Hand. J. Hertzberg.—p. 1893.
Follow-Up of Patients Operated on for Maxillary Sinusitis. H. Lindeman.—p. 1897.
Serum Iron in Leukemia, Malignant Lyphogranulomatosis and Polycythemia Vera (Erythremia). S. Dahl.—p. 1907.

Hygiea

Cases of Ethylene Glycol Intoxication. C. Widman.—p. 1921.
Ammonia Defense in Experimental Acidosis. B. Herner.—p. 1924.

Perforating Gastric or Duodenal Ulcer in Vestfold District Hospital, 1936-1944.—Of the 76 patients with perforating ulcer treated during this period 74 were men and 2 women, with the average age of 43. An increase in perforating ulcer occurred during the war. Saxholm states that resection is well borne by patients with perforation and gives better results than other operative methods. Resection was done in 64, suture in 11, suture and gastroenterostomy in 1. There were 10 deaths. The late results in 49 patients observed for from nine months to nine years show 27 well, 21 improved and 1 not improved; the results are better than the figures indicate, many patients classified as improved being on the borderline of cured. Because of the war information was not available on 17 patients. The mortality after resection was 6.2 per cent, while after 379 resections during the same period in ordinary ulcer without acute complications it was 4.7 per cent.

Book Notices

Neurosyphilis. By H. Houston Merritt, A.B., M.A., M.D., Professor of Clinical Neurology, College of Physicians and Surgeons, Columbia University, New York, Raymond D. Adams, M.A., M.D., Neuropathologist and Visiting Neurologist, Boston City Hospital, Boston, and Harry C. Solomon, B.S., M.D., Professor of Psychiatry, Harvard Medical School, Boston. Cloth. Price, $11. Pp. 443, with 58 illustrations. Oxford University Press, 114 5th Ave., New York 11, 1946.

This textbook on neurosyphilis is written from the interrelated points of view of the neurologist, neuropathologist and psychiatrist. The clinical and pathologic material on which it is largely based has been drawn from the three authors' extensive experiences at the Boston City Hospital and the Boston Psychopathic Hospital. Various sections of the book cover the clinical and pathologic aspects of the several types of neurosyphilis thoroughly and in logical sequence. Certain syndromes, e. g. syphilitic spinal spastic paraplegia (Erb), merit a more detailed consideration. Complete correlation between the clinical manifestations and the histopathology of such diverse syndromes as tabes dorsalis, dementia paralytica and the multiform lesions of meningovascular neurosyphilis is as yet not possible, but Merritt, Adams and Solomon have more closely approximated the correlation than have other authors lacking their combined breadth of view. The therapy of neurosyphilis is less adequately summarized. Notably lacking is any evaluation of the Dattner-Thomas concept of cerebrospinal fluid "activity" as determined by the cell counts and protein determinations. The usefulness of penicillin in the various syndromes of syphilis of the central nervous system is briefly discussed. This drug has proved to be less efficacious in primary optic atrophy than the authors' early experience suggested, but the prediction that "in paretic and possibly in other types of parenchymal neurosyphilis penicillin will be found to be most efficacious when used in conjunction with therapeutic fever" now appears to have been well grounded. Those interested in neurosyphilis and in the intricacies of neuropsychiatric diagnosis will find this a book of significant value.

Heredopathia atactica polyneuritiformis: A Familial Syndrome not Hitherto Described. A Contribution to the Clinical Study of the Hereditary Diseases of the Nervous System. By Sigvald Refsum. Translated from Norwegian by Claude Lillingston, M.D. Paper. Pp. 303, with 28 illustrations. Johan Grundt Tanum Forlag, Oslo; Mercators Tryckeri, Helsingfors, 1946.

During 1937-1943 an unusual syndrome was presented by 4 Norwegian patients who belonged to two different families and were treated in the neurological department of the Rikshospital. They presented an unusual syndrome and had previously been referred to at a neurologic demonstration at the Rikshospital in Oslo on June 7, 1944 at a staff meeting and at the ninth Congress of Scandinavian Neurologists on Sept. 23, 1945 at Stockholm. A short preliminary communication was published in *Nordisk Medisen.* The clinical picture has been mentioned by Professor Monrad Krohn in the Text Book of Internal Medicine, volume v, under the term "heredopathia atactica polyneuritiforms (Refsum)." As far as the author can ascertain, the familial syndrome has previously not been described.

The syndrome consists of hemeralopia, which occurred in all 5 patients, and atypical retinitis pigmentosa, which occurred in all 3 members of family B. In the 2 patients of family A the fundus could not be viewed adequately because of miosis. These 2 patients had concentric limitation of the field of vision in addition to hemeralopia. The syndrome is also characterized by a condition suggestive of chronic polyneuritis (decreased to absent deep reflexes), reduced position and vibration sense, deep muscle tenderness, inconstant superficial sensory signs, pains, paresthesias and ataxia mainly cerebellar in type and other cerebellar phenomena. Changes began in adult life and were insidious. Hemeralopia and visual field changes preceded disturbances of gait by years. One patient noticed remissions in periods of rest. Treatment was of no value, although in 1 patient there was a question of some objective improvement. There were no mental changes.

Three of the patients presented definitely pathologic electrocardiograms. Three of the patients presented sinus tachycardia. In the fifth case, death occurred suddenly and no electrocardiogram was performed. Both patients of family A died of suggestive respiratory paralysis. The cerebrospinal fluid of 3 patients showed an albuminocytologic dissociation with a normal cell count and a great increase of protein. Three patients had abnormal pupils. Two patients suffered from a neurogenic impairment of hearing. Two patients of family A showed symmetrical epiphysial dysplasia in the elbow, shoulder and knee joints.

Clinical analysis indicates a relationship to the heredoataxias and progressive neural amyotrophy. It is considered hereditary, possibly a simple recessive mode. Postmortem examination of 2 patients of family A suggests that the pathologic findings resemble the lipoidoses such as Niemann-Pick disease and familial amaurotic idiocy. Each case record is given in detail and then summarized. The symptomatology in general is then summarized. There is a detailed differential diagnosis with a bibliography of 817 references. The general summary is also in French and German. Further recognition and pathologic study of additional cases will prove this syndrome as a definite entity. From the genetic point of view it should be recognized to prevent its propagation.

Practical Handbook of the Pathology of the Skin: An Introduction to the Histology, Pathology, Bacteriology and Mycology of the Skin with Special Reference to Technique. By J. M. H. MacLeod, M.A., M.D., F.R.C.P., Physician and Hon. Director of the Pathological Department, St. John's Hospital for Diseases of the Skin, London, and I. Muende, M.R.C.P., M.B., B.S., Physician with charge of Pathological Department and Lecturer at St. John's Hospital for Diseases of the Skin, London. Third edition. Cloth. Price, $10.50; 50s. Pp. 415, with 152 illustrations. P. B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 49 E. 33d St., New York 16; H. K. Lewis & Co., Ltd., 136 Gower Street, London, W. C. 1, 1946.

The authors' purpose is more accurately described by the subtitle. The book deserves special recommendation for the clarity and balance used in presenting difficult technical subject matter. The more common diseases, as eczema, psoriasis and epithelioma, are discussed fully, while the authors fortunately resisted the temptation to dwell at length on rare conditions with bizarre pathologic pictures. Emphasis is placed on the mechanism of pathologic changes—on pathologic changes in motion as it were—and these changes are skilfully correlated with clinical findings. The book contains thirty-seven short chapters dealing with all phases of the subject. There are notes on the object and technic of biopsies, the preparation of sections and stains, embryology and the normal histology of the skin. The pathologic changes are considered as they affect the separate layers of the skin and its special structures and appendages: the blood vessels, hair, sweat glands and pigment. The pathologic changes are considered usually in the light of differential diagnosis. The section on vesicles, for instance, describes them as they occur in eczema, dyshidrosis, miliaria, scabies, varicella, herpes and pemphigus. Hyperkeratoses, edemas, dystrophies, atrophies and other pathologic states are similarly considered and so give a better comprehension of the various clinical pictures. In addition, the book also contains material of a type usually found in works on clinical pathology, such as methods for examining scales and blood smears and for the identification of various fungi and parasites that attack the skin. There are numerous well chosen illustrations in the form of drawings and photomicrographs, many of them in color. The book is well indexed. Altogether this is a simplified, well written, practical handbook that should be useful to both medical students and practitioners.

Pharmacy's Part in Society. By George Urdang, Ph.G., D.Sc.Nat., Sc.D. Cloth. Price, $1.05. Pp. 93, with illustrations. American Institute of the History of Pharmacy, Pharmaceutical Library, 457 Chemistry Building, Madison, Wisconsin, 1946.

This volume presents a brief historical sketch of the contributions of the science of pharmacy to the health and culture of the people of the world. Emphasis is placed on the scientific contributions of a number of famous members of the pharmaceutical profession to chemistry, botany, agriculture and medicine. The book is attractively printed and lavishly illustrated and should prove of interest to historically minded physicians and pharmacists.

Queries and Minor Notes

THE ANSWERS HERE PUBLISHED HAVE BEEN PREPARED BY COMPETENT AUTHORITIES. THEY DO NOT, HOWEVER, REPRESENT THE OPINIONS OF ANY OFFICIAL BODIES UNLESS SPECIFICALLY STATED IN THE REPLY. ANONYMOUS COMMUNICATIONS AND QUERIES ON POSTAL CARDS WILL NOT BE NOTICED. EVERY LETTER MUST CONTAIN THE WRITER'S NAME AND ADDRESS, BUT THESE WILL BE OMITTED ON REQUEST.

TREATMENT OF ARTERIOSCLEROTIC LEG

To the Editor:—Please discuss the treatment of a man aged 60 with moderately severe diabetes mellitus which is under excellent control. The patient has inadequate circulation of the foot, with an ulcer of the ankle. X-ray examination reveals extensive calcification of the posterior tibial vessel. Is there any way to decalcify this vessel?

M.D., New Mexico.

ANSWER.—Chronic ulcer at the level of the ankle in a man aged 60 afflicted with diabetic arteriosclerosis is apt to be due to the obliteration of arteries and probably the arterioles of the lower extremity. Often venous stasis or deep thrombophlebitis may be additional factors. Presuming that not only the blood sugar but the blood cholesterol is under sufficient control, the problem resolves itself into increasing circulation to the affected area. If the ulcer is infected, dressings with penicillin solution or jelly are helpful. Rest in bed for several weeks is important. If the foot and ankle are moist and cold but can be warmed up by a heat cradle on the abdomen, sympathetic activity can be abolished by paravertebral injections of procaine. Lumbar ganglionectomy is safe, simple and quite effective in experienced hands and if vascular involvement elsewhere, such as in the heart, kidneys or brain, is not prominent. If there is evidence of diabetic neuritis with intermittent "lancinating" pain, peripheral nerve crushing is of some benefit. Intermittent venous hyperemia produced by a blood pressure cuff and used by the patient himself is useful in suitable cases. Amputation may be inevitable if the leg remains intractably painful, if it is wholly useless or if ascending infection develops. The responsibility of directing treatment should be shared by the family physician and a consultant. The calcified vessels can neither be canalized nor decalcified, and only by increasing the caliber and number of collateral vessels can improvement be expected.

B. SUBTILIS IN VAGINAL CULTURES

To the Editor:—A woman aged 32 has been complaining of a profuse, persistent vaginal discharge of many years' duration. Repeated cultures of the discharge revealed only Bacillus subtilis. Please discuss treatment.

M.D., Maine.

ANSWER.—Bacillus subtilis is usually a contaminant. There are many causes for discharge from the vagina in a woman aged 32. These conditions include vaginal trichomoniasis, vaginal mycoses, foreign body in the vagina, cervicitis and excessive cervical secretion. Ordinarily cultures of vaginal discharge are a less satisfactory way of establishing a diagnosis because rarely will one find a single organism. There may be a great preponderance of one organism, but if one uses proper mediums and both aerobic and anaerobic cultural technics one should find several different types of bacteria. It is suggested that a careful study be made of a hanging drop and of a direct smear (stained by Gram's method). The treatment of course will depend on what is actually causing the condition. A thorough inspection of the cervix should be made. The cervix may be the primary focus even though there is some vaginitis. There is no good evidence incriminating B. subtilis as the offending organism. Hence further study is necessary either to establish this point or to arrive at a proper diagnosis.

MARRIAGE OF FIRST COUSINS

To the Editor:—A young couple desire to be married but fear to do so because they are first cousins. Careful questioning has failed to disclose any history of congenital deformity, epilepsy, diabetes, tuberculosis or nervous and mental disorders in any member of the family in the past two generations. The parties involved present no physical or psychiatric problems. Under these circumstances should there be any fear of unhealthy offspring as a result of this union? M.D., California.

ANSWER.—Most geneticists believe that there is no biologic objection to marriage of first cousins, if no undesirable inherited traits or extremes of personality occur in that part of the ancestry which they have in common. Ordinarily knowledge of the two preceding generations is sufficient to establish the facts.

POSSIBLE PSEUDOHEMOPHILIA

To the Editor:—A white boy aged 11 years, of Italian descent, has had recurrent severe epistaxis since infancy. His mother had the same condition but was relieved by operation on the nose. The nature of the operation is unknown. The boy has had nasal cauterization innumerable times with temporary relief. Physical examination, including examination of the nose, is negative. The only positive finding is an absence of clot retraction after twenty-four hours, with only negligible retraction after forty-eight hours. All other blood studies are within normal limits. There are no petechiae on the antecubital skin after fifteen minutes at a pressure of 85 mm. Hemorrhage stops with local application of ceanothyn but forms large clots which obstruct breathing. At the present time the patient is receiving ascorbic acid 75 mg. daily and rutin 20 mg. three times daily. Does this case fit the description of any of the lesser known blood dyscrasias? What treatment is suggested?

Robert E. Sinderbrand, M.D., Egg Harbor City, N. J.

ANSWER.—In the patient as described in the query two or more tests should be made of the coagulation time of venous blood (Lee-White method), bleeding time (both the Duke and Ivy methods), platelet count, clot retractility, prothrombin time, plasma fibrinogen and capillary fragility. The normal blood clot occasionally fails to retract unless loosened from the walls of the tube by a platinum wire.

In 1918 Glansmann (*Jahrb. f. Kinderh.* **88**:1 and 113) reported cases of a familial hemorrhagic diathesis characterized by a poor or incomplete clot retractility and a normal bleeding time, coagulation time and platelet count. He thought the condition was related to a platelet defect and called it hereditary hemorrhagic thrombasthenia. Similar cases have not been reported.

Von Willebrand (*Arch. f. klin. Med.* **17**:453, 1933) later described a syndrome which he designated as pseudohemophilia. The disease was hereditary and was associated with a tendency to bleed. Epistaxis was common. The bleeding time was regularly prolonged, but the coagulation time, platelet count and clot retractility were normal. Sixty-two cases from the literature meeting these criteria have been recently analyzed by Estren, Médal and Dameshek (*Blood* **1**:504 [Nov.] 1946) and they added 11 cases of their own. The clot retractility was abnormal in 6 out of 61 cases in which the test was performed. Somewhat less than half of the cases showed increased capillary fragility.

It is possible that the case in the query as well as other cases of familial epistaxis reported in the literature fall into the category of pseudohemophilia. The absence of visible lesions in the nose and the abnormality of the clot retraction are against the diagnosis of hereditary hemorrhagic telangiectasia.

There is no effective treatment for this condition. Nasal hemorrhage often can be controlled by the application of thrombin soaked gauze or of thrombin-fibrin foam. Blood transfusions usually have no effect on the bleeding but should be given for anemia resulting from hemorrhage.

CEREBRAL HEMORRHAGE AND MUSCULAR EXERTION

To the Editor:—A man aged 40 with known hypertension lifted a heavy object while working at his usual occupation. He was seized with unsteadiness, lapsed into a coma and died within an hour. The cause of death was given as arterial hypertension and massive cerebral hemorrhage. Is it fair to say that the effort involved in the lifting of the heavy object precipitated a rupture of a cerebral vessel previously damaged by arteriosclerosis or is it the present consensus that such an accident was purely fortuitous? M.D., Connecticut.

ANSWER.—With hypertension and cerebral arterial disease a cerebral hemorrhage may occur at any time without relationship to any effort or activity. As far as we know, hemorrhage is usually the end result of progressive disease uninfluenced by any temporary rise in blood pressure.

Blood pressure is temporarily raised by the lifting of a heavy object. It is logical to expect that such a rise in pressure increases the possibility of hemorrhage. If it does so, then the hemorrhage will take place during the time the pressure is raised. The increase in pressure from a lifting effort disappears immediately on cessation of the effort, so that any effect of the effort must ensue immediately. The assumption of cause and effect seems rational.

Logical though it may be, causal relationship of so common a condition cannot be accepted without examination in the light of clinical observation of a series of cases. Clinically, the evidence is not strong that cerebral hemorrhage is distinctly more common during effort than when the patient is at rest. However, most observers believe that hemorrhage is more frequent during sneezing, straining at stool and on muscular effort than can be ascribed to coincidence. These are activities that cause a temporary physiologic rise in blood pressure. Considering the data we must conclude that it is probable that in the case described in the query the lift was a factor in precipitating the hemorrhage.

JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, JANUARY—APRIL 1947

Titles have been listed or abstracts made of important articles in the following journals in the Current Literature Department of THE JOURNAL during the past four months. Any of the journals, except those starred, will be lent by THE JOURNAL to subscribers in continental United States and Canada and to members of the American Medical Association for a period not exceeding three days. Three journals may be borrowed at a time. No journals are available prior to 1936. Requests for periodicals should be addressed to the Library of the American Medical Association and should be accompanied by stamps to cover postage (6 cents if one and 18 cents if three periodicals are requested). Thus most of these journals are accessible to the general practitioner.

Acta chirurgica Scandinavica. Stockholm.
Acta clinica belgica. Brussels.
Acta dermato-venereologica. Stockholm.
Acta medica orientalia. Jerusalem.
Acta medica scandinavica. Stockholm.
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V 1
194

SUBJECT INDEX

This is an index to all the reading matter in THE JOURNAL. In the Current Medical Literature Department only the articles which have been abstracted are indexed.

The letters used to explain in which department the matter indexed appears are as follows: "BI," Bureau of Investigation; "E," Editorial; "C," Correspondence; "OS," Organization Section; "ab," abstracts; the star (*) indicates an original article in THE JOURNAL.

This is a subject index and one should, therefore, look for the subject word, with the following exceptions: "Book Notices," "Deaths," "Medicolegal Abstracts" and "Societies" are indexed under these titles at the end of the letters "B," "D," "M," and "S." State board examinations are entered under the general heading State Board Reports, and not under the names of the individual states. Matter pertaining to the Association is indexed under "American Medical Association." The name of the author, in brackets, follows the subject entry.

For author index see page 1369.

A

ACS (antireticular cytotoxic serum), death of Bogomolets, 123
A. F. of L.: See American Federation of Labor
A-N-1 Formula of Benson Laboratories, 131: 1421, Aug. 24, 1946
ASTRP: See Army, U. S., Specialized Training Reserve Program
ABADOL (2921 RP) treatment of toxic diffuse goiter, [Perrault] 353—ab
ABBOTT BROS. Compound, 422—BI
ABBOTT LABORATORIES and the A.M.A., [Fishbein] *687; *690; *762
president: R. M. Cain, death, 706
ABDOMEN: See also Gastrointestinal Tract; Pelvis; Peritoneum
Adhesions: See Adhesions
Ascites: See Ascites
disease, rebound tenderness in, and Rovsing's sign, 508
examination in small bowel obstruction, [Evans & Bigger] *514
Gaseous Distention: See Flatulence
pain, fatal acute porphyria, [Abbott] 723—ab
Pain (gas): See Flatulence
Surgery: See also Appendectomy; Appendicostomy; Cesarean Section; Gallbladder excision
surgery, curare in, [Howard] 204—ab
surgery, muscular relaxation with pentothal-oxygen-curare, [Davison] 1245—ab
surgery, visibility of operative field, [Cardoso] 652—ab
tumors, primary retroperitoneal, [Donnelly] 649—ab
ABNORMALITIES: See also under specific organ and region as Arteries, coronary; Heart
congenital hypoplastic anemia with, [Estren] 1306—ab
congenital malformations due to irradiation and malnutrition, [Keitel] 716—C
defects in newborn, infectious diseases in mother in pregnancy, [Swan] 1316—ab
ABORTION: See also Medicolegal Abstracts at end of letter M
criminal, court upholds conviction, O., 491
criminal, physician sentenced, N. J., 562
criminal, 3 sentenced, Minn., 490
diagnosis; use of metreurynter in uterine bleeding; positive Aschheim-Zondek test, 74
missed, 213
therapeutic, for erythroblastosis fetalis, 479—E
ABRAMS, ALBERT, review of book on spondylotherapy in 1911, [Fishbein] *765
ABSCESS: See also Suppuration; Ulcers; under organ affected as Brain; Breast; Liver
peritonsillar, penicillin for, [Rosenberg] 888—ab
Subdiaphramatic: See Diaphragm abscess
treatment, bacitracin, [Meleney & Johnson] *675
treatment, emetine, [Melchior] 503—ab
ABSTRACTS: See Journals
ACADEMY: See under names of specific academies as American Academy; under Section at end of letter S
of Medical Sciences of USSR, 713
of Medicine of Turin, 495
of Surgery, foreign members elected, France, 1234
ACARIASIS, pulmonary, or tropical eosinophilia, [Hall] 967—ab
ACCELERATION, protect aviators against effects of, [Behnke] *454
ACCIDENTS: See also Disability; Trauma; World War II, casualties; Wounds
Aviation: See Aviation
danger in kitchen, 1295
emergency hospital and ambulance centers, Los Angeles, 1227
ACCIDENTS—Continued
fatal, and disabling injuries, 1946 statistics from National Safety Council, 564
fatal, of physicians in 1946, 108—E
fatal, violent deaths in Cook County, Ill., 412
Industrial: See Industrial Accidents
Prevention: See National Safety Council; Safety
ACETYL - beta - methylcholine bromide: See Mecholyl Bromide
ACETYLCHOLINE treatment of paroxysmal tachycardia, [Segers] 729—ab
treatment of myasthenia gravis, 1252
ACHLORHYDRIA: See Stomach acidity
ACID, acetic, saline-glycerine mixture for debridement of burns, 811
acetylsalicylic, added to alcoholic beverages, effect, 1253
acetylsalicylic, aspirin poisoning, value of gastric lavage, 545—E
diallylacetic, bismuth salt of, deaths from Analbis Suppositories, 852—E; [Weinstein] 962—C
Amino Acids: See Amino Acids
aminoacetic (glycine) treatment of myasthenia gravis, 1252
para-aminobenzoic, in Rocky Mountain spotted fever, [Ravenel] *989
Ascorbic: See also Vitamins C
ascorbic, metabolism, [Johnstone] 647—ab
ascorbic, N.N.R., (Miller) 619; (Buffington's Inc.), 937
Ascorbic, Sodium Salt of: See Sodium ascorbate
Barbituric, Compounds: See Barbiturates
Cevitamic: See Acid, ascorbic
Citric: See also Lemon juice
citric, synthesis, evidence in man, [Strom] 202—ab
dehydrocholic (D-cholic), action, 146
dehydrocholic, N.N.R., (Miller; Harrower) 619
fatty (essential), and eczema, [Hansen] 1240—ab
fatty, new vitamin in butter, 1299
folic, in macrocytic anemias, [Berman] 127—ab; [Goldsmith] 501—ab
folic, in pellagrous glossitis, [Spies] 425—ab
folic, in pernicious anemia, [Harrison] 574—ab; [Meyer] 1306—ab
folic, in pernicious anemia fails to prevent neurologic relapse, [Heinle & Welch] *739
folic, in possible subacute combined degeneration, 1043
folic, in tropical sprue, [Suarez] 724—ab; [Manson-Bahr] 894—ab
folic, panhematopoietic stimulus, [Doan] 128—ab
folic, use to avoid allergy to liver extract, [Sullivan & Broun] *178
lactic, injection in osteoarthritis, [Mawson] 352—ab
mandelic, in urinary infections, [Pool & Cook] *585
Mesoxalic, Ureide of: See Alloxan
Nicotinic: See also Vitamins B_1
Nicotinic, Diethylamide of: See Nikethamide
nicotinic, for headache, 1044
nicotinic, Niacinamide, N.N.R., (Harrower; Vale) 695
nicotinic, sodium nicotinate or nicotinic acid amide for migraine, 812
oxalic, effect on calcium metabolism; protects against erosion of dental enamel, 1010—E
phosphatase (serum) estimation in prostate cancer, [Herbert] 69—ab
Picric: See Trinitrophenol
vaccenic, new vitamin in butter, 1299
ACID-BASE BALANCE, bicarbonate and renal regulation of, 777—E
ACIDITY, Gastric: See Stomach acidity
ACIDOPHILUS Milk: See Milk
ACIDOSIS: See Acid Base Balance
ACNE: See also Furunculosis
tropical, [Novy] 889—ab
ACROMEGALY and cardiomegaly, [Schornagel] 1172—ab
ACTINOMYCES: See also Streptomycin
griseus (Waksman), antidotal property of filtrates, 960
ACTINOMYCOSIS due to Nocardia asteroides, [Kirby] 571—ab
ACTIVITY, Early Rising After Operation: See Convalescence
ADAMS, JOHN C., U.S. Navy assignments, 488
ADDICTION: See Alcoholism; Meperidine; Morphine; Narcotics
ADDISON'S ANEMIA: See Anemia, Pernicious
ADDISON'S DISEASE, diagnosis, water test, [Levy] 136—ab
in Negro, [Conn] 128—ab
treatment, adrenal graft, [Broster] 68—ab
ADEMO Tablets, 264—BI
ADENOMA, bronchial, [Holley] 573—ab; (lung resection) [Tricerri] 895—ab
Nontoxic, of Thyroid: See Goiter
of islands of Langerhans in pregnancy, [Pompen] 1317—ab
of large intestine; relation to cancer, [Helwig] 1313—ab
Toxic, of Thyroid: See Goiter, Toxic
ADENOMYOSIS: See Endometriosis
ADHESIONS, abdominal, postoperative, [Green] 723—ab
ADHESIVE strapping for low back pain, [Schaubel] 648—ab
ADOLESCENCE, syphilis higher among teen age boys and girls, Mich., 792
ADRENALIN: See Epinephrine
ADRENALS: See also Addison's Disease
cortex, hormone producing tumor, [Spence] 1311—ab
cortex, possible masculinizing tumor, 213
graft for Addison's disease, [Broster] 68—ab
Hormone (sympathetic): See Epinephrine
tumors, pheochromocytoma, [Espersen] 142—ab
tumors, pheochromocytoma, role in malignant hypertension, [Washington] 724—ab
ADVERTISING by physicians, [Fishbein] *838
Committee of A.M.A., 1923, [Fishbein] *932
Cooperative Advertising Bureau, founded in 1912, [Fishbein] *767
Cooperative Medical Advertising Bureau, [Weld] 553—ab; [various authors] 629—ab
medical editor consults his readers, [Wiprud] 624—ab
medical, ethics of, in 1865-1866, [Fishbein] *24; *25; (in 1883) *239; *240
newspaper, and state societies, [various authors] 628—ab
of A. M. A. JOURNAL, etc., growth from 1898 to 1946, [Fishbein] *605
of commercial laboratories, 1922, [Fishbein] *926
of proprietaries and nostrums in JOURNAL, 1894, [Fishbein] *239; *240; *390; *391; *464; *470; *535; *607; *608; *612; *681; *683
of proprietary infant foods, 1915, [Fishbein] *837
products accepted for advertising to public, (Council discusses), 850
AEROBACTER aerogenes, urinary tract infection, streptomycin for, [Adcock & Plumb] *579
AERONAUTICS: See Aviation
AERO-OTITIS Media: See Otitis Media
AFRICA, immunizations for Kenya Colony, 434
AFTERBIRTH: See Placenta
AGE, Adolescent: See Adolescence
at death of physicians in 1946, 108—E
effect on blood pressure, [Russek] 127—ab
limits for university professors, Italy, 880
middle, toxic goiter in, [Whishaw] 352—ab
of Nobel Prize winners, 296—ab
Old: See Old Age

AGGLUTINATION, inhibition test in influenza vaccination, [Florman] 128—ab
of red cells by mononucleosis serums, [Burnet] 67—ab
Rh: See Rh Factor
test for mumps antibody, [Burnet] 67—ab
AGGLUTINOGEN, Rh: See Rh Factor
AGRANULOCYTOSIS, ACUTE, induced by arsenotherapy, [Fisher] 1305—ab
induced by gold, BAL for, [Lockie & others] ★754
induced by sulfonamide, penicillin cures, [Faber] 968—ab
induced by thiouracil, 544—E
medullary hypoplasia, [Alvarez] 1248—ab
treatment, penicillin, [Mackenzie] 1316—ab
AGRICULTURE: See Farmers; Rural Communities
AIR: See also Oxygen
borne infection, control, [Perkins] 1304—ab
disinfection, glycol vapors for, 696—E
disinfection, ultraviolet radiation for, (Council report), 936
Embolism: See Embolism, pulmonary
Injection of: See Pneumogram (cross reference); Pneumothorax, Artificial
pollution, soot fall averages 112 tons per square mile, N. Y. C., 562
pollution, study of sunshine, smoke and dust, Chicago, 334
AIRBORNE Medical Society organized, England, 261
AIR MEDAL: See World War II, Heroes
AIR PASSAGES: See Respiratory System
AIRPLANES: See Aviation
ALASKAN clams, survey, 708
ALBERT Medal: See Prizes
ALBUMIN in Urine: See Albuminuria
ALBUMINURIA, Bence-Jones proteinuria relation to, [Bayrd & Heck] ★150
ALCOHOL: See also Whisky
Addicts: See Alcoholism
drugs added to alcoholic beverage, effect, 1233
Isopropyl: See Isopropyl Alcohol
prescribing liquor, 1923, [Fishbein] ★931
psychiatric problem and, 561
referendum and A.M.A., [Fishbein] ★923; ★926
Summer School of Alcohol Studies at Yale University, 636
synergism between barbiturates and, [Ramsey] 350—ab
ALCOHOLISM, chronic, research into causes, N. Y., 335
clinic, bills in Congress, 632—OS
commission on, Conn., 1227
committee for education on, Rochester, N. Y., 876
complications: liver cirrhosis, liver extract intravenously for, [Labby & others] ★1186
conference on, Calif., 334
liquor offenses and driving while intoxicated, F. B. I. report, 416
treatment, aversion (conditioned reflex), [Shanahan] 135—ab
treatment, Keeley cure, [Fishbein] ★386; ★387
ALEPPO Boil: See Leishmaniasis, cutaneous
ALIMENTATION: See Infants, feeding
ALKYLATION plants, urinary fluoride excretion in employees, [Largent] 1309—ab
ALLEN'S Method: See Anesthesia, refrigeration
ALLERGENS; ALLERGY: See Anaphylaxis and Allergy
ALLIES: See World War II
ALLOCATION: See Priorities and Allocations
ALLOXAN diabetes, 195; 496
ALOE, plus tissue therapy of retinitis pigmentosa, [Lipkins] 652—ab
ALOPECIA, Dr. Marshall's Scalp Medications, 568—BI
seborrheica: dandruff, 734
ALPHA Fagarine: See Fagarine
Omega Alpha Lecture: See Lectures
ALTITUDE, High: See also Aviation
high, acclimatization to anoxia, [Houston] 656—ab
high, concepts, [Behnke] ★450
high, decompression sickness, [Burkhardt & others] ★373; [Behnke] ★452
high, decompression sickness and alveolar carbon dioxide tension, [Hodes] 719—ab
high, decompression sickness, drug prevention, [Williams] 1308—ab
high, effect of diet and exercise on bends at, [Burkhardt & others] ★373
high, ionosphere, insects survive flight by rocket, 874—OS
high, liquid oxygen converter for breathing purposes, 559
ALUMINUM, effect on lungs of rabbits, [King] 208—ab
hydroxide gel (colloidal) for peptic ulcer, [Jankelson] 1240—ab
ALVARENGA Prize: See Prizes
AMARILLO, Texas, Q fever in, [Topping & others] ★813; [Irons & Hooper] ★815; [Irons & others] ★819; [Cox & others] ★820
AMAUROSIS: See Blindness
AMBLYOPIA: See Blindness
AMBULATION: See Convalescence
AMBULANCE centers, emergency, Los Angeles, 1227
AMEBIASIS: See also Colitis, amebic
[Ellenberg] 424—ab
clinical forms, 881
complications: hepatic, 496
complications: pleurisy, [Carruthers] 1246—ab
treatment, penicillin, [Knoll] 1242—ab
treatment, sulfadiazine, [Ellenberg] 424—ab
treatment, various drugs, 1042
AMERICAN: See also Inter-American; Latin America; National; Pan American; South American; United States; list of societies at end of letter S
Academy of Pediatrics (study of child health service), 40
Anti-Arthritis Association, organized, 1230
Association for Advancement of Science, (resolution on National Science Foundation), 180—OS
Association for Labor Legislation, [Fishbein] ★923
Association of Medical Editors, [Fishbein] ★240
Association of Medical Record Librarians, 1157—E
Association of School Administrators (health challenge of our schools), 696—E
Board for certification of general practitioners, 43; 942—OS
Board of Internal Medicine, 943—OS
Board of Obstetrics and Gynecology, 956
Board of Ophthalmology (directory of certified specialists), 257
Board of Pathology, (examination dates changed) 1165
Board of Psychiatry and Neurology (examination), 191
Board of Surgery (plan of organization), 337
Bureau for Medical Aid to China, 709
Cancer Society, (clinics, inspection by A. C. S.) 132: 1092; 133: 38
Casualties: See World War II
College of Physician, Joint Committee for Coordination of Medical Activities (*formerly* the Committee on Postwar Medical Service): See American Medical Association
College of Physicians (research fellowships awarded), 492
College of Radiology (graduate course) 337
College of Surgeons (inspection of American Cancer Society clinics; A. M. A. Reference Committee report), 132: 1092; 133: 38; (fellowship pledge clause on fee splitting and rebates) [Patek] 715—C; (formation in 1914) [Fishbein] ★770
College of Surgeons, Joint Committee for Coordination of Medical Activities (*formerly* Committee on Postwar Medical Service): See American Medical Association
Dermatological Association, organized 1876 (correction) 1025
Federation of Labor, plans for sickness benefits, [Dickinson] ★1285
Foundation: See Foundations
Health Resorts: See Health resorts
Hospital Association, medical record librarians, 1157—E
Institute of Nutrition Award: See Prizes
Journal: See Journals
Legion, Hawley criticizes for opposing medical reforms, 609—OS
MEDICAL DIRECTORY, history of, [Fishbein] ★612; ★682; ★685; ★687
Medical Golf Association (tournament entry blanks), 631—OS
Medical Journalist: See Journals
Medical Teaching Mission to Czechoslovakia, 546—E
Nurses Association, [Naffziger & others] 1168—C
Pharmaceutical Manufacturers Association Award: See Prizes
Physicians Literary Guild, 257; 1165
Physicians Serving at the Front: See World War II, medical officers
Public Health Association Committee (glycol vapors for disinfecting purposes), 696—E
Q Fever: See Q Fever
Red Cross: See Red Cross
Society for Study of Arteriosclerosis being organized, 1025
Soldiers, etc.: See World War II
Surgical Association, (correction) 1025; (resolutions on nursing problem) 1156—E; [Naffziger & others] 1168—C
University of Beirut, New & Nonofficial Remedies given to, (Council discusses), 850
Women's Association Medal: See Prizes
AMERICAN MEDICAL ASSOCIATION
Advertising Committee, 1923, [Fishbein] ★932
advertising, growth from 1898-1946, [Fishbein] ★605
AMERICAN MEDICAL DIRECTORY, history of, publication by Dr. G. H. Simmons, [Fishbein] ★612; ★682; ★685; ★687
Anderson (Donald G.), new Council secretary, 871—OS
animal experimentation defended by, [Fishbein] ★241; ★388; ★470
Annual Conference of Secretaries and Editors (proceedings), 548—OS; 623—OS
AMERICAN MEDICAL ASSOCIATION — Continued
Annual Congress on Medical Education and Licensure (program), 34—E; 59; (proceedings) 856—OS
Archives: See subhead: Journals (special)
Atlantic City Centennial Celebration, 32—E; 35; 45—OS; 631—OS; (General Scientific Meetings; program) 1010—E; 1013
auto emblem, 1918, [Fishbein] ★843
Board of Public Instruction, first report, 1908, [Fishbein] ★689
Board of Trustees, history of, [Fishbein] (first) ★238; ★239; (takes over control of the JOURNAL) ★317; (authority of) ★470; (in 1898) ★472; (responsibility of) ★607; (great power of A. M. A. concentrated in; Dr. McMurtry's tribute to) ★684; (Reference Committee reports) ★685; (*New York Medical Record* attacks on) ★685; ★686; (in new building in 1907) ★687; (publish minutes in 1910) ★762; (needs more meetings; executive committee to meet monthly) ★848; (reorganization in 1923) ★930; (W. P. Eagleton's request to dissociate editorship and general management, 1923) ★931
Board of Trustees (report), 39; (support standardization of iodized salt to prevent goiter) 620—E; (position on bills on education, security and health department) 1015
Building: See subhead: Headquarters
Bulletin, 1922, [Fishbein] ★926
Bureau of Exhibits (Reference Committee report), 40
Bureau of Health Education: See also subhead: Radio Program
Bureau of Health Education (Reference Committee report), 40
Bureau of Information (Joint Committee report), 41
Bureau of Investigation (Food and Drug Administration: adulterated and misbranded products), 264; 422; 568; 883
Bureau of Legal Medicine and Legislation: See also Laws and Legislation, weekly summary; Medicolegal Abstracts at end of letter M
Bureau of Legal Medicine and Legislation (physicians federal income tax), 401—E; 402—OS; (analysis of Taft-Smith-Ball-Donnell national health bill) 855—E; 868—OS; (general regulations promulgated under federal hospital survey and construction act) 946—OS; (first director, Dr. Woodward, and his report in 1923) [Fishbein] ★929; ★931
Bureau of Medical Economic Research (Reference Committee report), 40; (fundamental requirements of insurance), 481—E; [Dickinson] ★483; (medical service areas in U. S.) 1011—E; [Dickinson] ★1014; (medical groups in U. S., 1946) [Dickinson] ★1222; (trend toward labor health and welfare programs) [Dickinson] ★1285
Bureau on Medical Legislation at headquarters, [Fishbein] ★683
By-Laws, amendment (Reference Committee report), 38
cancer control, motion on dispersal of federal funds for, 40
Centennial: See subheads: Atlantic City Centennial Celebration; History; Radio Program
Chemical Laboratory (Reference Committee report), 39
Chicago Session of House of Delegates, proceedings, 35
Committee: See also subheads: Joint Committee; Reference Committee
Committee on American Health Resorts activities referred to Council on Physical Medicine, 936
Committee on Anesthesia, 1910, [Fishbein] ★763
Committee on Cancer, 1914, [Fishbein] ★770
Committee on Centennial Celebration (report), 35
Committee on Defense of Medical Research, 1910, [Fishbein] ★763
Committee on Legislation, 1905-1909, [Fishbein] ★681; (1910) ★763
Committee on Medical Ethics dealing with specialization, reports, 1866, [Fishbein] ★25
Committee on National Emergency Service (questionnaires to physicians in civilian practice during war), 480—E; [Dickinson] 548—ab; 550—ab
Committee on Ophthalmia Neonatorum introduces silver nitrate to prevent blindness, 1908, [Fishbein] ★689
Committee on Reorganization of A. M. A., 1901, [Fishbein] ★537
Committee on Rural Medical Service (report), 37; (questionnaire) 941—OS
Committee to consider revision of constitution and by-laws (Reference Committee report), 37
Conference: See subhead: Annual Conference
Congress: See subhead: Annual Congress
Constitution and By-Laws, revision (Reference Committee report), 37
Cooperative Medical Advertising Bureau [Weld] 553—ab; [various authors] 629—ab; (founded in 1913) [Fishbein] ★767

V 1 194

133
947

AMERICAN MEDICAL ASSOCIATION — Continued
Council on Defense of Medical Research, [Fishbein] ★691
Council on Foods and Nutrition (Reference Committee report), 39; (some basic research needs in nutrition) [Jeans] ★245; (statement on pasteurization of milk) 240—E; (use of tin seal) 321; (decision on iodized salt and goiter) 620—E
Council on Health and Public Instruction, [Fishbein] ★763; ★764; ★766; ★768; (committee report on social insurance) [Fishbein] ★836 ff.; (review of its work, 1910-1919) ★845; ★923
Council on Industrial Health (Reference Committee report), 40; (joint report on pyogen, spray promoted to industry as cold cure) 694
Council on Medical Education and Hospitals (Dr. Welskötten chairman), 34—E; (survey of medical schools) 109—E; (plan for uniform intern placement) 267; (Dr. Victor Johnson accepts appointment with Mayo Foundation) 327—OS; (residency and fellowship programs must provide training in applied basic medical sciences) 697—E; 717; (new secretary: Dr. D. G. Anderson) 871—OS; (hospital service) ★1065; 1155—E; (schools for technicians, medical record librarians) ★1144-1150
Council on Medical Education, history of, [Fishbein] ★687; ★690; ★769; ★839; ★927
Council on Medical Service (report and supplementary report), 35; (medical service plan news) 46—OS; (seal of acceptance to various plans) 112—OS; (medical facilities available in rural Virginia) 251—OS; (regional conference) 407
Council on Pharmacy and Chemistry, history of, [Fishbein] ★611; (cartoons ridiculing) ★681
Council on Pharmacy and Chemistry (Therapeutic Trials Committee report on cost of clinical research), ★30; (Reference Committee report) 39; (methionine in preventing and treating liver injury) 107; (use of its seal) 321; 850 (dangers of tetrathionate therapy of thromboanglitis obliterans) 693; (joint report on pyogen, spray promoted to industry as "cold" cure) 694; (annual meeting) 850; (ointments containing estrogenic substances) 1009
Council on Physical Medicine (Reference Committee report), 39; (use of its seal) 321; (procedure for evaluating percentage loss of hearing in medicolegal cases) ★396; (home diathermy) 541; (meeting, Dec. 13-14, 1946) 936; (orthoptics) [Lancaster & Lancaster] ★1211
Councils, development of, [Fishbein] ★681
daylight saving time advocated by, [Fishbein] ★848
Directory Department: See also subhead: American Medical Directory
Directory Department (Reference Committee report), 39
Directory Report Service, [Fishbein] ★923
enemies of, 1906, [Fishbein] ★686; (first organized attack as a medical trust), [Fishbein] ★761; (Lydston) ★769
Fellowship to Veterans Administration physicians, A. M. A. Resolution on, 39
finances, [Fishbein] (1897) ★169; ★605; (1907) ★682; ★688
golf tournament, 631—OS
headquarters (permanent), history of, [Fishbein] (Chicago vs. Washington) ★384; ★389; ★392; (61 Market St., Chicago) ★466; ★467; ★468; (at 535) ★608
health and physical fitness project, 945—OS
History, Centennial Celebration: See subhead: Atlantic City Centennial Celebration
HISTORY OF AMERICAN MEDICAL ASSOCIATION, [Fishbein] ★23; ★100; ★174; ★235; ★310; ★383; ★464; ★533; ★605; ★681; ★761; ★836; ★923; 938—E
history, New York U. scroll commemorates founding of, 877
history, postage stamp will commemorate centennial, 1219—OS
history (Reference Committee report), 39
history: semicentennial year: Philadelphia, 1897, [Fishbein] ★467; ★468; ★469
Home: See subhead: Headquarters
hospital service in the U. S. ★1065; 1155—E
hospitals and health of people, [Parran] ★1047
hospitals approved for internships, number, ★1081
hospitals registered by, ★1083-★1143
hospitals, standardization by, 1918, [Fishbein] ★843
House of Delegates, history of, [Fishbein] (admission of Negro delegate) ★101; (institution in 1902) ★606; (speaker) ★606; (chairman for) ★682; (attacks nostrums, 1915) ★836; (speaker as its presiding officer, 1916) ★838; (first chairman: Dr. Hubert Work) ★840
House of Delegates (minutes of Chicago session, Dec. 1946) 35
Hoxsey—cancer charlatan and, 774—E; (correction) 957
Hurty (J. N.) letter for improved sanitation for pullman cars to, [Fishbein] ★607
Hygeia, history of [Fishbein] ★924; ★925; ★926; ★929; ★930; ★931; ★933
incorporated with national charter, 1905, [Fishbein] ★682
insignia adopted in 1910, [Fishbein]] ★763
insurance legislation, stand against, explained by speaker, 482—OS
Internships and residencies approved by, additional list, ★1078
Johnson (Victor) accepts appointment with Mayo Foundation, 327—OS
Joint Committee for Coordination of Medical Activities, (meeting, Oct. 12, 1946) 41; (meeting, Jan. 11, 1947) 941—OS
JOURNAL abstracts criticized 1902-1904 [Fishbein] ★607; (from German journals, 1919) ★849
JOURNAL, advertising in, drive against nostrums, etc. (1894) [Fishbein] ★390; ★391; (1895) ★464; ★470; (1901-1904) ★607; ★608; ★612; (1905-1906) ★681; ★683
JOURNAL, A.M.A. resolutions on including medical activities in Puerto Rico in, 40
JOURNAL, automobile number, [Fishbein] ★761
JOURNAL, book reviews and editorials, signing of [Fishbein] (1894) ★391; (1895) ★464
JOURNAL, censoring scientific papers 1900, [Fishbein] ★535
JOURNAL, costs, 1920, [Fishbein] ★924
JOURNAL, editorial on deaths of physicians first published, Jan. 9, 1904, [Fishbein] ★612
JOURNAL, editors, [Fishbein]] (first: Dr. N. S. Davis) ★239; ★311; (Dr. Hamilton to succeed Dr. Davis) ★317; (Dr. Culbertson, 1891) ★384; ★387; (Dr. Hamilton, 1888-1889, 1893) ★316; 317; ★389; (death of Dr. Hamilton, 1898) ★473; (Dr. Simmons, 1898) ★472; ★473; (death of Dr. Hyde assistant to editor; appointment of Dr. Fishbein) ★769; (appointment of Dr. Fishbein as editor, 1924) ★935
JOURNAL, educational number (first) in 1896, [Fishbein]] ★468
JOURNAL, founding of, [Fishbein] (suggested by Dr. S. D. Gross in 1869) ★26; ★100; (birth of) ★235; (gains, in 1885) ★310; (editorial changes, 1888) ★316; (suggested by Dr. J. B. Flint in 1852) ★687
JOURNAL in Spanish, 1918, [Fishbein] ★843
JOURNAL, Index, (1899) [Fishbein] ★475; (1900) ★533
JOURNAL, new machinery for printing , 1901, [Fishbein] ★607
JOURNAL, Queries and Minor Notes, [Fishbein] ★609
JOURNAL, (Reference Committee report), 39
JOURNAL, special issue, 1887, [Fishbein] ★314
JOURNAL, Tonics and Sedatives, birth, 1903, [Fishbein] ★611
JOURNAL, want old copies for libraries in Netherlands, [Taylor] 345—C; [Kouwer] 715—C
journals (special), American Journal of Diseases of Children, 1910, [Fishbein] ★762; ★764
journals (special), Archives of Dermatology and Syphilology editorial board established, 1918, [Fishbein] ★848
journals (special), Archives of Internal Medicine established, 1907, [Fishbein] ★688
journals (special), Archives of Otolaryngology, [Fishbein] (requested in 1913) ★767; (founded in 1923) ★931
journals (special), Archives of Surgery, 1911, [Fishbein] ★762; ★765; ★844; ★848
journals (special), on public health, requested in 1910, [Fishbein] ★762; ★766
journals (special), 1910, [Fishbein] ★764
Judicial Council, history of, [Fishbein] (creation of, in 1873) ★103; (in 1911) ★764; (asked to define "sectarian practice" and "physician" in 1924) ★933
Judicial Council, (report of Dr. Ivy on atrocities by German physicians), 35; (Reference Committee report) 40
Library, history of, [Fishbein] (1870) ★101; ★238; (1894) ★391; (transferred to Newberry Library of Chicago 1895) ★466
Library of Films, new additions, 802
medical colleges rated by, [Fishbein] ★763
Members, first woman, Dr. S. H. Stevenson, [Fishbein] ★175
Mohler (Charles) Assistant Business Manager: death, 45—OS
National Conference on Rural Health, (program) 326—OS; (proceedings) 778—OS; NEW AND NONOFFICIAL REMEDIES, distributed to American University of Beirut, 850
New York State Medical Society and, [Fishbein] ★238; ★241
nomenclature, disinterest in, in 1873 [Fishbein] ★103
nurses training schools recommended, 1868, [Fishbein] ★26
Officers, (Reference Committee report) 37; (death in 1946) 109—E
participation in World War I, [Fishbein] ★838; ★839; ★841; ★842; ★848
patents and, [Fishbein] ★471; ★770
President's address (Reference Committee report) 37
President-Elect Bortz, 1012—E
President-Elect West address (Reference Committee report), 37
President-elect West resigns, 1012—E; 1016
Proceedings of Chicago Session of House of Delegates, 35
Public Health Education Committee of Women, 1910, [Fishbein] ★762
public relations, question of publishing Rich Report (Reference Committee report), 38
pure food law should be amended, 1911, [Fishbein] ★765
QUARTERLY CUMULATIVE INDEX MEDICUS, 1916, [Fishbein] ★839; (1922) ★927
radio program, (centennial broadcasts: "Doctors—Then and Now") 250—OS; (electrical transcriptions: "Medicine Serves America") 324—E; 326; ("Dr. Graham and Family") 325—E; 326; 1159; (costs of) [Bauer] 630—ab
Reference Committee in Executive Session, (report) 35
Reference Committee on Amendments to Constitution and By-laws, (report) 35
Reference Committee on Credentials, (report) 35
Reference Committee on Legislation and Public Relations, (report) 38
Reference Committee on Medical Education, (report) 40
Reference Committee on Medical Service, (report) 35; 38
Reference Committee on Miscellaneous Business, (report) 35; 40
Reference Committee on Reports of A.M.A. Officers, 37
Reference Committees, first appointment, in 1902, [Fishbein] ★609
representative Dr. Rubinow sent to Europe to study sickness insurance, 1913, [Fishbein] ★770
resolution defending animal experimentation, 1884 [Fishbein] ★241
resolution on A.M.A. Fellowship to Veterans Administration physicians (Reference Committee report), 39
resolution on appointment of surgeons general, (Reference Committee report), 39
resolution on Bituminous Coal Mine Wage Agreement, 35
resolution on expert witnesses, [Fishbein] ★238
resolution on fee splitting, [Fishbein] (1902) ★609; (1913) ★768
resolution on freedom of choice of physician by insured in 1917, [Fishbein] ★841
resolution on inclusion in JOURNAL of medical activities in Puerto Rico, (Reference Committee report), 40
resolution on program of health legislation beneficial to the people (Reference Committee report), 40
resolution on proprietaries in 1879, [Fishbein] ★178
resolution on Study of Child Health Service by American Academy of Pediatrics, (Reference Committee report) 40
resolution on Veterans Administration contracts, 35
resolution on Woman's Auxiliary, 38
resolution protesting action against Dr. Pallen accused of poisoning water in Croton reservoir, 1865, [Fishbein] ★24
school health interests, 696—E
schools for technicians, medical record librarians approved by, ★1144-1150
Scientific Exhibit, 45—OS
Scientific Exhibit, first in 1899, [Fishbein] ★475; (guides for) ★477
Secretary: Dr. Lull, (report) 39
Secretary (permanent), [Fishbein]] (Dr. Atkinson, 1872) ★102; (1882) ★238; (battle over, in 1895) ★465; (Dr. Simmons, 1895) ★464; ★465; (question of) ★467; ★470; ★473; (Dr. Craig, 1911) ★765; ★769
Section on Anesthesia requested, 1921, [Fishbein] ★925
Section on Experimental Medicine and Therapeutics, symposium on treatment: jaundiced patients; [Snell] ★1175
Section on Gastroenterology and Proctology, created in 1913 [Fishbein] ★769; ★770
Section on Genitourinary Diseases, 1910, [Fishbein] ★763
Section on History of Medicine (Reference Committee report) 40
Section on Miscellaneous Topics, [Fishbein] ★928
Section on Ophthalmology, 1906, [Fishbein] ★685
Section on Orthopedic Surgery, [Fishbein] (1895) ★465; (1912) ★766
Section on Surgery, General and Abdominal, (symposium on treatment of wounds) [Lyons] ★215; [Stewart] ★216; [Snyder] ★219; [Rustigian & Cipriani] ★224; (discussion) 229
sections, (in 1900) [Fishbein] ★534; (in 1917) ★841
sections, papers presented before, resolutions on, in 1865, [Fishbein] ★24
sections, reorganization, 1915, [Fishbein]] ★837

AMERICAN MEDICAL ASSOCIATION — Continued
special train trouble, 1896, [Fishbein] *466; 467; 471
state and county secretaries, names and addresses, possible for A. M. A. to publish? 630—OS
television programs, 326—OS
Therapeutic Trials Committee, (Cost of Clinical Research), *30; (Council discusses) 851
Treasurer, 1894, R. J. Dunglison, [Fishbein] *391
U. S. Dept. of Health urged by, [Fishbein] *769
U. S. Dept. of Health, Education and Security, A. M. A. attitude explained, 1015—OS
Washington office (Reference Committee report), 37
Woman's Auxiliary: See Woman's Auxiliary
AMIGEN, sensitivity to, [Poncher] 198—C; [Ratner] 497—C
AMIGRIN treatment of myasthenia gravis, 1252
AMINO ACIDS: See also Amigen; Methionine
alimentation, [Remington] 890—ab
essential; recent developments in biochemistry, Netherlands, 56
nitrogen balance, 247-E
para-**AMINOHIPPURATE** sodium plus penicillin treatment of endocarditis, [Loewe] 61—ab
AMINOPHYLLINE: See Theophylline ethylenediamine
AMINOTHIAZOLE, treatment of toxic goiter, [Perrault] 353—ab; 544—E
AMMONIUM, tetraethylammonium ion in vascular disease and causalgia, [Berry] 66—ab
AMNIOTIC FLUID, intrauterine respiration of fetus, [Windle & Becker] 125—C
AMPHETAMINE (Benzedrine) sulfate and barbiturates, antagonism, 280
sulfate, effect on pilots, [Newman] 270—ab
sulfate treatment in tuberculosis of lung, [Houghton] 805—ab
sulfate treatment of obesity, [Freed] *371; [Kunstadter] 800—C
AMPUTATION: See also Limbs, Artificial
amputee clinic, N. J., 562
amputees (civilian), needs of, 699—OS
finger, tendon sutures in, 358
finger tip, new method for, [Kutler] *29
home-coming problems of amputee in movie: "The Best Years of Our Lives," 46—OS
midthigh, best artificial leg for? 656
phantom limb, section of spinal cord for, [Browder] 272—ab
traffic regulations for car-driving amputees, 1219—OS
traumatic neuromas, [Cieslak] 722—ab
AMYLOIDOSIS, diagnosis, congo red test in, [Selikoff] 804—ab
primary, of lungs, [Dirkse] 499—ab
AMYTAL, sodium, in testing for latent anxiety, [Susselman] 500—ab
ANALBIS Suppositories, deaths from, 852—E; [Weinstein] 962—C
ANALGESIA: See Anesthesia; Pain, relief of
ANAMILO Club of New York, organization of laryngectomized patients, 146
ANAPHYLAXIS AND ALLERGY: See also Asthma; Dermatitis venenata; Eczema; Hay Fever; Urticaria
allergens, chemical nature, [Rhoden] 728—ab
allergens, federal biologics regulations revised, 855—E
allergic pulmonary reactions of Loeffler's syndrome, 325—E; 776—E
allergy forum at Reading, Pa., 707
allergy in production of lesions in disease, 776—E
allergy research fund (Luzier's) to American College of Allergists, 1294
clinics in South America, 564
heredity, possibility in child whose mother has ragweed allergy? 1174
periarteritis nodosa and hypersensitivity, 620—E
sensitivity to amigen, [Poncher] 198—C; [Ratner] 497—C
sensitivity to benadryl [Geiger & others] *392; [Schwartzberg & Willerson] *393; [Weil] *393
Sensitivity to Food: See Food
sensitivity to furacin, [Morin] 963—C
Sensitivity to Light: See Light
sensitivity to liver extract, avoiding; use of folic acid, dried stomach and iron, [Sullivan & Broun] *178
sensitivity to penicillin, procaine intravenously for, [Rosellini] 204—ab; [Dressler & Dwork] *849; [Abram] 1301—C; [Waldbott] 1301—C
sensitivity to riboflavin, 434
sensitivity to soap in eczema, [Beek] 895—ab
sensitivity to sulfathiazole and *sod* penicillin, [Abram] 1301—C
sensitivity to sulfonamide, 435
serum sickness from influenza vaccine fatal, [Curphey] *1062
serum sickness, treatment with benadryl, [Peterson & Bishop] *1277
treatment, benadryl, danger of self medication, [Borman] *394
treatment, histamine, [Brown] 207—ab
ANAPHYLAXIS AND ALLERGY—Continued
treatment, pollen desensitization in pregnancy, contraindicated? 1174
treatment, urinary proteose, [Rhoads] 135—ab
ANASTOMOSIS: See Arteries
ANATOMY, Morbid: See Pathology
residency and fellowship programs must provide for training in, 697—E; 717
ANCYLOSTOMIASIS, fatal, [Zimmerman] 268—ab
hookworm anemia, [Stransky] 1306—ab
ANDERSON, DONALD G., A. M. A. appointment, 871—OS
ANDROGENS, estrogen ratio disturbance, periodic swelling of breast in men, 146
testosterone, growth promoting agents, 898
testosterone propionate to control menorrhagia, [Greenblatt] 723—ab
treatment of cancer, 734
treatment of functional uterine bleeding, 1253
treatment of migraine, [Bartstra] 1317—ab
ANDRUS, CARLTON L., U. S. Navy assignments, 488
ANEMIA: See also Anemia, Pernicious
angina pectoris and, [Gelinas] 502—ab
aplastic, and quinacrine dermatitis, [Drake] 134—ab
effects of sulfonamides on fetus, 970
heart in, severe type, [Gelfand] 651—ab
hookworm, [Stransky] 1306—ab
Hypochromic: See Plummer-Vinson Syndrome
hypoplastic congenital, with developmental defects, [Estren] 1306—ab
in scurvy, [Wade] 64—ab
macrocytic, avoid allergy to liver extract; use folic acid, dried stomach and iron, [Sullivan & Broun] *178
macrocytic, folic acid for, [Berman] 127—ab; [Goldsmith] 501—ab
of thermal burns, [Moore] 426—ab
sickle cell, race specific disease, 33—E
splenic, Gaucher's method for staining kerasin, 496
treatment, methionine, [Gajdos] 574—ab
ANEMIA, PERNICIOUS, complications: possible subacute combined degeneration, 1043
diagnosis, probable gastrointestinal lesion, 278
treatment, folic acid, [Harrison] 574—ab; [Meyer] 1306—ab
treatment, folic acid; fails to prevent neurologic relapse, [Heinle & Welch] *739
ANERGY in infants' skin to diphtheria, [Wright] 573—ab
ANESTHESIA: See also Anesthesiology; Anesthetists
A. M. A. Committee on, in 1910, [Fishbein] *763
Anesthesia (motion picture review), 285; 346
apparatus, new safety code, England, 797
caudal continuous, cause of fetal and maternal deaths, [McCormick] 801—C
caudal continuous, graduate course by USPHS, 702
caudal continuous, in labor 249—E [Collins] 649—ab
choice in orthopedic surgery, [Dillon] *829
Cold: See Anesthesia, refrigeration
curare in abdominal surgery, [Howard] 204—ab
fatalities, number which occur annually during general and spinal anesthesia, 507
history, ether and humbug, [Graham] *97
in cesarean section, 881
in Labor: See also Anesthesia, caudal continuous
in labor [Volpitto] (correction) 258
local, method of prolonging action with benzocaine, 498
pentothal sodium intravenously for oral surgery, 812
refrigeration, [Crossman & Allen] *377
saddle block; [Parmley] 129—ab
Spinal: See also Anesthesia, caudal continuous; Anesthesia, fatalities
spinal, complications, paralysis and impotence? [Mason] 345—C
spinal, headache after, vitamin B_1 for, [Bazzocchi] 430—ab
ANESTHESIOLOGY department established at St. Luke's, Spokane, 1165
ANESTHETISTS, nurse, intern, and physician, [Graham] *99
nurse, in all hospitals, *1077
ANEURYSM, Arteriovenous: See Fistula, arteriovenous
ANGINA, Agranulocytic: See Agranulocytosis, Acute
Monocytic: See Mononucleosis, Infectious
Vincent's, penicillin for, [Hopp] 133—ab; [Page] 427—ab; [Hopp] 645—C
Vincent's, vitamin C for [Schnurman] 1036—ab
ANGINA PECTORIS, anemia and, [Gelinas] 502—ab
diagnosis, ruptured intervertebral disk simulating, 1030
treatment, nitroglycerin tablets, age and effectiveness, [Sagall] 271—ab
treatment, surgical, [Saccomanno] 1241—ab
treatment, thiouracil, disadvantages, [Di Palma] 127—ab
ANGIOMA, facial, treatment (reply) [Ronchese] 578
ANGIOSCOTOMA in prolonged mild anoxia, [Smith] 1308—ab
ANGIOSPASM, Peripheral: See Raynaud's Disease
ANGLO-: See under England
ANHIDROSIS: See Sweat
ANIMAL EXPERIMENTATION, A. M. A. in defense of, [Fishbein] (in 1884) *241; (in 1893) *388; (in 1897) *470
antivivisection bills in Congress, 184—OS; 327—OS; 631—OS; 948—OS
Carlson, (A. J.) recommends counter antivivisection bills, 51
Parran (T.) criticizes antivivisection in Kober Lecture, 1159—OS
watch the antivivisectionists, 182—E
ANIMALS: See also Birds; Cats; Cows; Dogs; Horses; Rats; Rodents
efficiency to produce human food, [Maynard] 202—ab
Experimentation with: See Animal Experimentation
feeds (best), question of, to improve milk supply, 775—E
marine, dermatitis venenata from contact with [De Oreo] 720—ab
Q fever in livestock handlers, [Topping & others] *813; [Irons & Hooper] *815; [Irons & others] *819; [Cox & others] *820
tissue extracts, effects on wound healing, [Hoffman] 720—ab
virus infections in man traced to, [Meyer & Eddie] *822
ANKYLOSTOMIASIS: See Ancylostomiasis
ANNALS: See Journals
ANNUAL Conference: See American Medical Association
Congress: See American Medical Association
ANOMALIES: See Abnormalities; under organ or region affected
ANOXIA: See Oxygen deficiency
ANTERGAN, histamine antagonist, [Friedlaender] 1309—ab
ANTHOCYANINURIA: See Urine
ANTHIOMALINE treatment in tuberculosis, [Rose] 269—ab
ANTHRACITE Miners: See Miners
ANTIBIOTICS: See also Penicillin; Streptomycin
bacitracin, [Meleney & Johnson] *675
British Medical Bulletin symposium, 478—E
from Ramalina reticulata: California Spanish moss, [Marshak] 1245—ab
ANTIBODIES: See also Agglutination
mumps, agglutination test for, [Burnet] 67—ab
protective, against human epidemic influenza, 882
Rh: See Rh Factor
test (neutralizing), for toxoplasmic choroiditis, [Johnson] 647—ab
where obtain antiserum for influenza A and B for measuring in patient's serum? 810
ANTICOAGULANTS: See Blood coagulation; Dicumarol; Heparin
ANTIDOTES, property of filtrates of Penicillium notatum, 33—E
property of filtrates of Actinomyces griseus, 960
ANTIGENS: See Antibodies
Rh: See Rh Factor
Vi: See Typhoid
ANTIHEMOPHILIC globulin, 1044
ANTIHISTAMINE: See Benadryl; Histamine
ANTI-INFECTIVES: See Bactericides; Sterilization, Bacterial
ANTI-LEWISITE, British: See BAL
ANTIMONIATE of N-methyl glucamine treatment of kala-azar, 420
ANTIMONY: See also Fuadin
compounds in tuberculosis, [Rose] 269—ab
lithium antimony treatment of filariasis, [Brown] 268—ab
ANTIRETICULAR Cytotoxic Serum: See Bogomolets
ANTISEPTIC: See also Bactericides; Sterilization, Bacterial
Golden Key Antiseptic Medicated Cream, 568—BI
ANTISERUM: See Influenza; Plague
ANTITOXIN: See Diphtheria; Scarlet Fever
ANTI-URIC, 422—BI
ANTIVIVISECTION: See Animal Experimentation
ANTON'S Syndrome, [Brockman] 889—ab
ANURIA: See Urine, suppression
ANUS: See also Rectum
Artificial: See Colostomy
Fistula: See Fistula
perianal dyscrasias, [Granet] 127—ab
Pruritus: See Pruritus
Sphincter: See Sphincter Muscles
surgery, hemostatic dressings, [Rosser] 893—ab
ANXIETY, latent, sodium amytal in testing, [Susselman] 500—ab
Neurosis: See Neurosis
AORTA, cholesterol content, [Faber] 70—ab; 652—ab
retrograde abdominal aortography, [Farinas] 272—ab

AORTIC ARCH, congenital vascular ring causes tracheal and esophageal obstruction, [Sweet] 1310—ab
AORTOGRAPHY: See Aorta
APHTHOUS FEVER, funds required for research, Mexico, 788—OS
APOPLEXY: See Brain hemorrhage
APPARATUS: See also Anesthesia; Medical Supplies; Roentgen Rays
control of vaginal urinary incontinence due to fistulas, [Castallo] *244
impact decelerator, [Bierman & others] *522
used for tidal drainage or irrigation, [Bumpus & others] *366; [MacNeill] 1237—C
APPENDECTOMY, preventive use of penicillin and sulfadiazine, [Griffin & others] *907; [Brown] 1241—ab
sequels: fecal fistulas, 1254
APPENDICITIS, [Moses] 205—ab
acute, in aged, [Simpson] 1037—ab
acute, pathogenesis, [Bohrod] 885—ab
mortality, responsibility, Denmark, 123
symptoms from excessively filled bladder, [Klasman] 1172—ab
Treatment: See Appendectomy
APPENDICOSTOMY in chronic ulcerative colitis, [Yeomans] 272—ab
APPENDIX, intussusception [Milin] 208—ab
Surgery: See Appendectomy; Appendicostomy
APPETITE, curbing with amphetamine sulfate in obesity, [Freed] *371; [Kunstadter] 806—C
ARACHNIDISM: See Spider
ARACHNOIDITIS, diagnosis, National Neurologic Congress discuss, 1236
ARCHIVES: See American Medical Association, journals (special)
ARCHIVOS: See Journals
ARGENTAFFIN cells in pancreatic islet cell tumors, [Hultquist] 730—ab
ARGENTINEAN Congress of Surgery (17th), 343
ARMED FORCES: See Army; Navy; World War II
ARMS: See also Extremities; Fingers; Hand; Shoulder; Wrist
Amputation: See Amputation
blood pressure in, [Stewart] 424—ab
ARMSTRONG'S Drops, 568—BI
ARMY, Canadian, venereal disease incidence in, vs. circumcision, [Wilson] 1243—ab
ARMY, UNITED STATES: See also World War II
air base hospitals taken over by tuberculosis board, Fla., 791
Air Force, liquid oxygen converter for breathing purposes, 559
Air Surgeon, M. C. Grow; (Jeffries Award to) 408; (promoted) 1018
aural rehabilitation center opened, Washington, D. C., 408
Commendation: See World War II, Heroes
construction program, 1947, 47
deferment policy, physician veterans protest against, 184—OS
dietitians needed, 408
food service supervisors, 47
Freer (Arden) retires, 329
Hospitals: See Hospitals, army
INDEX CATALOGUE of Surgeon General's Library, [Fishbein] *103
Institute of Pathology, (new director: Col. Dart) 252; (study on sudden death in young men) 325—E
laboratory specialists, conference 1018
medical consultants division; new head; Col. Dooling, 329
medical corps, professional training, 946—OS
Medical Department benefits of proposed legislation, 873—OS
Medical Department deep x-ray centers for research and treatment, 329
Medical Department, hearings on bill to establish medical service corps, 789
Medical Department Research and Graduate School new name, 789
medical exhibit open to public, 252
medical general laboratory (406th) in Tokyo, 186
Medical Library, 186; [Fishbein] *311; (new director: Col. McNinch) 329 (microfilm service available to physicians) 789; (Association of Honorary Consultants) 1018; (acquires Chinese Golden Mirror of Medicine) 1018
medical officers appointed, 329
medical officers attending venereology classes, 186
medical officers, lack of, is Army's chief problem, Eisenhower states, 1015
medical officers lent to Veterans Administration, 113
Medical Officers Separated from Service: See World War II, medical officers
medical officers, training program, changes, 1218—E
merger, research phase, House members criticize, 788—OS
Military Academy, courses in mental hygiene proposed, 327—OS
model of new artificial hand, 408
Nurses: See Nurses
occupies St. Luke's Hospital in Tokyo, 789
Officers: See also Army, U. S., medical officers

ARMY, UNITED STATES—Continued
officers (civilian), retirement of, 401—E
personnel, annual physical examinations, 47
psychiatrists confer at War Department, 408
ration, cost increases 32%, 789
soldiers' Christmas mail lost at sea, 486
Specialized Training Reserve Program, 874—OS
typhus in, after immunization, [Sadusk] *1192
venereal disease control council established, 486
venereal disease, drive against vice, 112—OS
week celebration, April 6-12, 486
widows may claim terminal leave pay, 329
Women's Medical Specialist Corps, 632—OS
ARRHENOMIMETIC Phenomenon: See Virilism
ARRHYTHMIA: See Auricular Fibrillation; Auricular Flutter
ARSENIC and ARSENIC COMPOUNDS: See also Arsphenamine; Melarsen
toxicity, agranulocytosis, [Fisher] 1305—ab
toxicity, BAL for, [Eagle] 136—ab [Sulzberger & Baer] *293; [Cohen & others] *749
toxicity, methionine to prevent liver injury, (Council report), 107
treatment of urinary infections, [Pool & Cook] *585
ARSPHENAMINE, toxicity, bone marrow impairment, [Lachnit] 967—ab
toxicity, acute yellow atrophy of liver, 1156—E
ART, Massachusetts Physicians Art Association, 1023
Portraits: See Portraits (cross reference)
ARTERIES: See also Aorta; Blood Vessels; Ductus Arteriosus; Veins
carotid (internal), primary thrombosis, [Miletti] 430—ab
Coronary: See also Angina Pectoris
coronary, coffee not contraindicated, 73
coronary disease and flying, 898
coronary disease, functional tests in diagnosis, 481
coronary (left), anomalous origin, [Lyon] 886—ab
Coronary Occlusion: See also Thrombosis, coronary
coronary occlusion (acute), treatment, 357
coronary, sudden death in young men, 325—E; [Moritz] 721—ab
Disease (Obliterative): See Thrombo-angiitis obliterans
Embolism: See Embolism
Fistula: See Fistula
Inflammation: See Endarteritis; Periarteritis
Pressure in: See Blood Pressure
Pulmonary: See Embolism
Pulmonary, Valve of: See Pulmonary Valve
roentgen study, retrograde abdominal arteriography, [Farinas] 272—ab
roentgen study, in renal diagnosis, [Wagner] 965—ab
Sclerosis: See Arteriosclerosis
surgery, anastomosis of a systemic artery to pulmonary artery for blue baby, 248—E
tibial (anterior), acute spasm of, causes paralysis, [Holstein] 382—ab
truncus arteriosus in infancy, [Taussig] 1303—ab
ARTERIOGRAPHY: See Arteries, roentgen study
ARTERIORRHAPHY, transvenous, for arteriovenous fistula, [Heringman & others] *665
ARTERIOSCLEROSIS, American Society for Study of, being organized, 1025
atherosclerosis in dogs, [Steiner] 133—ab
coronary, sudden deaths of young soldiers, 325—E; [Moritz] 721—ab
treatment, inject 1 (—) histidine monohydrochloride-sodium ascorbate [Wirtschafter & Widmann] *604
treatment of arteriosclerotic leg, 1320
treatment, sympathectomy, [de Takats & Evoy] *441
ARTERIOVENOUS Fistula: See Fistula
ARTERITIS: See Endarteritis; Periarteritis
ARTHRITIS: See also Rheumatism; Medicolegal Abstracts at end of letter M
American Anti-Arthritis Association, organized, 1230
Chronic or Atrophic: See Arthritis, rheumatoid
Hypertrophic: See Osteoarthritis
Marie-Strümpell: See Spine, arthritis
muscle lesions in, [Gibson] 67—ab
polyarthritis (acute), epidemic, [Goswell] 1246—ab
polyarthritis, cardiac disorders in, [Appelgren] 895—ab
rheumatoid, copper salts for, [Forestier] 1317—ab
rheumatoid, Empire Rheumatism Council study cause of, 341
rheumatoid, gold poisoning, BAL for, [Cohen & others] *749; [Ragan & Boots] *752; Lockie & others] *754
rheumatoid, heart in, [Rogen] 1315—ab
rheumatoid, neostigmine for muscle spasm in, [Wramner] 1248—ab
rheumatoid, pleuropneumonia-like organisms relation to, [Wallerstein] 137—ab

ARTHRITIS—Continued
Spine: See Spine
suppurative, intra-articular penicillin for, [Tucker] 892—ab
treatment, histamine, 212
ARTHROPOD-borne virus types of encephalitis, [Meyer & Eddie] *827
ARTHROPLASTY, vitallium mold, in femur fractures, [Smith-Petersen] 1308—ab
ARTICLES: See also Journals
scientific papers, censoring, 1900, [Fishbein] *535
ARTIFICIAL Limbs: See Limbs, Artificial
Pneumothorax: See Pneumothorax, Artificial
Teeth: See Teeth
ASBESTOS, effect on lungs of rabbits, [King] 208—ab
ASBESTOSIS: See Pneumonoconiosis
ASCARIASIS, surgical aspects, [Barber] 1315—ab
ASCARIS of common bile duct, [Guzman] 804—ab
ASCHHEIM-Zondek Test: See Pregnancy, diagnosis
ASCITES, surgical treatment, [Crosby] 203—ab
intravenous liver extract therapy of cirrhosis effect on, [Labby & others] *1185
transfusion of ascitic liquid in cirrhosis, [Acevedo Olvera] 1317—ab
ASCORBATE: See Calcium ascorbate; Sodium ascorbate
ASCORBIC Acid: See Acid
ASPHYXIA: See also Carbon Monoxide poisoning
fatal plastic bib, 121
Local: See Raynaud's Disease
ASPIRATION type of congenital tuberculosis, [Pagel] 141—ab
of amniotic fluid by fetus, [Windle & Becker] 125—C
ASPIRIN: See Acid, acetylsalicylic
ASSAULT and Battery: See Medicolegal Abstracts at end of letter M
ASSOCIATION: See also American Association; American Medical Association; list of Societies at end of letter S
of American Medical Colleges (survey of medical schools) 109—E; 945—OS; (plan for uniform intern placement) 267
of Honorary Consultants to Army Medical Library, 1018
ASTHENIA: See also Myasthenia gravis; Neurasthenia
neurocirculatory, ocular manifestations, [Harrington] *670
ASTHMA, etiology, bee sting, [Reed] 68—ab
etiology, sulfathiazole, [Rosberg] 1248—ab
high altitude and, traveling in airplane harmful to patient? 812
Himrod's Asthma Powder, 883—BI
treatment, procaine intravenously, [Durieu] 729—ab
treatment, radon nasopharyngeal applicator in children, [Ward & others] *1060
ATABRINE: See Quinacrine
ATAXIA: See Tabes Dorsalis
ATELECTASIS: See Lung, collapse
ATHEROMATOSIS and cholesterol deposition, [Faber] 70—ab
ATHEROSCLEROSIS: See Arteriosclerosis
ATHLETICS: See Exercise
ATKINSON, WILLIAM B., A.M.A. Secretary, [Fishbein] *102; *238; (battle over in 1895) *465
ATLANTIC City Session: See American Medical Association
ATMOSPHERE: See Air
ATOMIC ENERGY and your future health, [Lyon] 725—ab
fission products, (Council discusses), 850
medical forum, 52
President's Commission, 327—OS
scientists report on effect of radiation at Hiroshima and Nagasaki, 1159—OS
treatment of incurable diseases, 631—ab
treatment of malignant tumors, [Warren] *462
warfare, medical aspects, 1225
ATROCITIES committed by German physicians, (Dr. Ivy's report on), 35; (ethical responsibility of German profession) [Wertham] 645—C
ATROPHY: See Liver; Nerves, optic; Testis
Muscular: See Dystrophy
Sudeck's: See Osteoporosis, post-traumatic
ATROPINE sulfate to prevent post-traumatic pneumonia, [Phillips] *161
ATTORNEYS, doctors asked to join with, in combating court problems, 631—OS
AUDIOMETRY: See Deafness, diagnosis
AURICULAR FIBRILLATION, transitory, [Jervell] 504—ab
AURICULAR FLUTTER, transitory, [Jervell] 504—ab
treatment, lanatoside C and quinidine sulfate, [Tandowsky] 424—ab
AURINE, now sold as Ourine, 422—BI
AUROTHERAPY: See Gold
AUTOINFECTION: See Infection
AUTOMATISM: See Mental Tension

AUTOMOBILES, A.M.A. emblem for, 1918, [Fishbein] *843
liquor offenses and driving while intoxicated FBI report, 416
number of J.A.M.A. in 1916, [Fishbein] *761
priorities for physicians (Joint Committee report), 44
tires (old) mosquitoes in, from Pacific, 559; [Pratt] 725—ab
traffic regulations for car-driving amputees, 1219—OS
traffic safety awards, 1294
trailer camps, clinics for children in, Calif., 706
AUTOPSIES: See also Coroners
on Okinawans, [Steiner] 133—ab
performance in approved intern hospitals; also hospitals having highest rates, *1082
AUTOVACCINATION: See Vaccination
AVERSION Treatment: See Alcoholism
AVIATION: See also Altitude, high
acceleration, protect against effects, [Behnke] *454
Air Surgeon, M. C. Grow, 408; 1018
Airborne Medical Society formed, England, 261
airplane accidents, National Safety Council report, 564
airplane accidents, protection against injury in, [Behnke] *455
airplane tires (old) filled with water, mosquitoes transported by, 559; [Pratt] 725
coronary disease and flying, 898
DDT sprayed by, Florida, 489
decompression sickness and alveolar carbon dioxide tension, [Hodes] 719—ab
decompression sickness, diet and exercise affect bends, [Burkhardt & others] *373
decompression sickness, drug prevention, [Williams] 1308—ab
dermatoses in aircraft workers from chromates, [Ellis] 1244—ab
doctor makes mercy flights piloting his own plane, 788—OS
flight nurses graduate, Texas, 1018
flights at high altitude, [Behnke] *450
flying personnel, glucose vs. anoxia in, 776—E
high altitude, and asthma; traveling in airplane harmful? 812
insecticidal sprays in aircraft, [Garnham] 140—ab
insects survive flight into ionosphere by rocket, 874—OS
John Jeffries Award to Brig. Gen. Grow, 408
liquid oxygen converter for breathing purposes, 559
medicine in Sweden, 421
medicine research by War Department, 950
medicine, School of, of U. S. Navy, 488
ocular manifestations of psychosomatic disorders, [Harrington] *670
passenger comfort in, [Tuttle] 1308—ab
pilots, blood carboxyhemoglobin concentration and hypoxia in, [Pitts] 1304—ab
pilots, effect of amphetamine sulfate on, [Newman] 270—ab
pilots, restraining harness for, impact decelerator, [Bierman & others] *522
AVITAMINOSIS: See Vitamins, deficiency; Vitamins B Complex; etc.
AVOCATIONS: See Physicians, avocations
AWARDS: See Prizes
for Military Service: See World War II, Heroes
AYERST, McKenna and Harrison Fellowships: See Fellowships
AZOTEMIA: See Uremia

B

BACILLUS: See Bacteria
BACITRACIN treatment of surgical infections, [Meleney & Johnson] *675
BACK: See Spine
Pain: See Backache
BACKACHE: See also Sciatica
treatment, adhesive strapping for low back pain, [Schaubel] 648—ab
treatment, curare for muscle spasm in acute low back pain, [Schlesinger] 499—ab
BACON, vegetables with, Beech-Nut, 937
BACON LECTURE: See Lectures
BACTEREMIA: See Meningococcemia
BACTERIA: See also Bacteriology; Pneumococcus; Staphylococcus; Tubercle Bacillus; etc., under names of organs
Abortus Infection: See Brucellosis
acid fast (false) fat-coated saprophytes in wound, [Berczeller] 804—ab
bacitracin sensitive, [Meleney & Johnson] *679
Coli: See Escherichia coli
culture medium (urea) to differentiate Proteus and paracolon, [Christensen] 136—ab
Ducrey's: See Chancroid
Friedlander: See Klebsiella pneumoniae
in Air: See Air disinfection
in Blood: See Meningococcemia
in open wounds, [Rustigian & Cipriani] *224
Infection: See Infection
Lactobacillus Casei Factor (synthetic): See Acid, folic
BACTERIA—Continued
Lysis: See Bacteriolysis
Mallei: See Malleomyces mallei
Proteus: See Proteus
Pyocyaneus: See Pseudomonas aeruginosa
streptomycin dosage required to inhibit, [Adcock & Plumb] *583
subtilis in vaginal cultures, 1320
Tularense: See Tularemia
BACTERICIDES: See also Sterilization, Bacterial
detergent for cooking and eating utensils, [Guiteras] 803—ab
BACTERIOLOGIC WARFARE: See Biologic Warfare
BACTERIOLOGY: See also Bacteria
residency and fellowship programs must provide for training in, 697—E; 717
BACTERIOLYSIS, initiated by notalysine, [Hutter] 1247—ab
BACTERIUM: See Bacteria
BAKER, NORMAN, cancer charlatan, 774—E; (correction) 957
BAKERS: See Bread
BAL, development and use; especially in arsenical dermatitis, [Sulzberger & Baer] *293
treatment, clinical uses, [Eagle] 136—ab
treatment of acute gold and arsenic poisoning, [Cohen & others] *749
treatment of acute mercury poisoning, [Longcope] 136—ab
treatment of gold dermatitides, [Ragan & Boots] *752
treatment of reactions to gold, [Lockie & others] *754
BALDNESS: See Alopecia
BALL-Donnell-Taft Smith Bill: See Taft
BALLOON, rubber, dermatitis due to, 1174
BALM, 422—BI
BANDAGES: See Dressings
BANK (therapeutic): See Blood Transfusion; Bones; Eyes
BANKS: See Investments
BANTING, FREDERICK, liberty ship named in honor of, 1294
BARBITURATES: See also Pentobarbital; Pentothal Sodium; Phenobarbital
alcohol and, synergism between, [Ramsey] 350—ab
alcoholic beverages doped with, 1253
amphetamine sulfate and, antagonism of, 280
poisoning (acute), gastric lavage in, 545—E
sleeping pills, federal officials puzzled by large U. S. consumption, 405—OS
tests for; effects of prolonged use on sexual function in men? 279
treatment, convulsive seizures after withdrawal, [Osgood] *104
treatment, intravenous, for oral surgery, 812
BARLEY cereal, Gerber's Ready to Serve, 937
BARNARD Hospital Lecture: See Lectures
BARRÉ-Guillain Syndrome: See Guillain
BARTHOLIN'S GLANDS, and Cowper's gland, analogy between, (reply) [Movitt] 734
infection of cyst; penicillin or excision for, 1253
BASAL METABOLISM: See Metabolism
BASEDOW'S Disease: See Goiter, Toxic
BASIC ENDOCRINES nostrums, 422—BI
BASIC SCIENCE, course, Ill., 49
residency and fellowship programs must provide training in, Council decision, 697—E; 717
state board (composite) and, [Various authors] 630—ab
BATES Vitamin Preparations, 264—BI
BATHS: See Health resorts; Hydrotherapy
Mineral Water: See Mineral water
BATTLE Casualties: See World War II, casualties
BCG Vaccination: See Tuberculosis, immunization
BEARD, MARY, death, 191
BEARD, folliculitis of, penicillin for, [Hopkins] 886—ab
BEAUTY CULTURE: See Cosmetics
BEAWUN Vitamin B1 Tablets, 568—BI
BEBEERINE dimethylether methochloride, curare substitute, Brazil, 882
BED Capacity: See Hospitals
Rest, Early rising after operation: See Convalescence
Wetting: See Urine incontinence
BEDSON, S. P., Chadwick lecture on laboratory diagnosis of virus infections, 1299
BEES, sting, asthma and urticaria after, [Reed] 68—ab
BEETS, tint or color urine blood red? 1254
BEHAVIOR: See Mental Hygiene
BEHCET'S syndrome, [Thomas] 1246—ab
BELGIUM, Medical Days of Brussels, 263
radium given to Switzerland, 118
BELL'S Palsy: See Neuropathy of facial nerve
BELTONE Hearing Aid, 543
BENADRYL, histamine antagonist, [Friedlaender] 1309—ab
hypertension and, 812
toxicity, danger of self medication and large dosage, [Borman] *394
toxicity, prolonged reaction, histamine intravenously, [Schwartzberg & Willerson] *393; [David & Karr] 1301—C
BENADRYL—Continued
toxicity, unusual reaction, [Geiger & others] *392
toxicity, unusual side effect, [Weil] *393
treatment of allergic conditions, [Brown] 207—ab
treatment of hypersensitivity to sunlight and dysmenorrhea, [Tyson] 137—ab
treatment of lupus erythematosus, 213
treatment of penicillin urticaria, [Willcox] 428—ab; [Callaway] 891—ab; [Pillsbury & others] *1255
treatment of serum sickness, [Peterson & Bishop] *1277
BENCE-Jones Protein: See Protein
"BENDS" at high altitude, diet and exercise affect, [Burkhardt & others] *373
BENZEDRINE: See Amphetamine
BENZOCAINE: See Ethyl Aminobenzoate
BENZOHYDRYL Alkamine Ethers: See Benadryl
BEQUESTS: See Donations (cross reference)
BERIBERI, cerebral, Wernicke's encephalopathy, [de Wardener] 1246—ab
BESNIER-Boeck-Schaumann Disease: See Sarcoidosis
BESREDKA, cancer treatment by autovaccination, 111—E; [Gross] 800—C
BEST, CHARLES H., awarded honorary degree, Netherlands, 712
BETATRONS treatment of cancer, proposed erection of, 556—OS
BEVAN, ANEURIN, conflict on National Health Service Act, 643; (B.M.A. decides to negotiate with Minister of Health) 797; 880
BEVAN, ARTHUR DEAN, surgical journal, 1919, [Fishbein] *845
BEVERAGES: See also Coffee; Milk; Water
Alcoholic: See Alcohol; Whisky
containers, cadmium lined, danger of, [Monnet] 729—ab
BEVERIDGE Plan: See National Health Service Act
BIB, plastic, fatality from, 12!
BICARBONATE of Soda: See Sodium bicarbonate
BICYCLE, moral hygiene, 1896, [Fishbein] *468
BIERMER'S Anemia: See Anemia, Pernicious
BIGG'S Lecture: See Lectures
BILE Acid: See Acid, dehydrocholic
secretion, effects of cholagogues on coronary occlusion, 146
BILE DUCTS: See also Bile; Biliary Tract; Gallbladder; Liver
ascaris, [Guzman] 804—ab
calculi, diagnosis, [Mirizzi] 730—ab
BILHARZIASIS: See Schistosomiasis
BILIARY TRACT: See also Bile Ducts; Gallbladder; Liver
drainage to relieve pruritus, [Varco] 1314—ab
obstruction, proved in jaundice, [Snell] *1176; *1177
obstruction (neoplastic), surgical treatment, [Stevens] 732—ab
surgery of lower, [Crile] 648—ab
surgery, postoperative dyskinesia, [Colp] 890—ab
BILIRUBIN in Blood: See Blood
BILLINGS, FRANK, active in 1899, [Fishbein] *475
personal attack by Dr. Ochsner, state medicine, 1921, [Fishbein] *925
BILLS, Doctor's: See Fees
Legislative: See Laws and Legislation
BIOCHEMISTRY, recent developments, Netherlands, 56
residency and fellowship training in, 697—E; 717
BIOLOGIC PRODUCTS: See also Serum; Toxin; Vaccines
federal regulation, revision and expansion, 855—E
BIOLOGIC WARFARE, forum, 563
BIOPSIES: See Liver
BIRDS, diagnosis of psittacosis in children, [Meyer & Eddie] *824
captive wild, diet and tuberculosis in, [Ratcliffe] 888—ab
BIRTH: See Labor
in Hospitals: See Hospitals, maternity
Multiple: See Twins
Rate: See Vital Statistics
Weight: See Infants, Newborn, weight
BIRTH CONTROL: See Contraception
BISMUTH salt of diallylacetic acid, deaths from Analbis Suppositories, 852—E; [Weinstein] 962—C
subnitrate, methemoglobinemia from; treatment with methylene blue, [Wallace] *1280
subsalicylate in oil with chlorobutanol, N.N.R., [Abbott] 937
BITE: See Spider
BLACKWATER FEVER, Malarial: See Malaria
BLADDER: See also Urinary System
cancer and prostatic carcinoma, 279
cervicocystopexy, new method, 56
excessively filled, causes appendicitis symptoms,, [Kisman] 1172—ab
fetal bones in, from ectopic pregnancy, [Forshaw] 429—ab
Fistula: See Fistula
inflammation and edema, cystoscopic finding in fistula, [Barnes & Hill] *456

BLADDER—Continued
paralysis in spinal cord injury, [Bumpus & others] *366; (apparatus used for tidal drainage or irrigation) [MacNeill] 1237—C
paralysis, transurethral resection for, [Emmett] 206—ab
BLECKWENN, WILLIAM J., memorial fund, 1230
BLEEDERS: See Hemophilia
BLEEDING: See Hemorrhage
BLEPHAROCONJUNCTIVITIS: See Eyelids
BLINDNESS: See also Conjunctivitis, infectious
acute in newborn; Vision
amaurosis fugax, [Harrington] *670
amaurosis in perforating and bleeding duodenal ulcer, [Forgarasi] 1248—ab
angiospastoma in prolonged mild anoxia, [Smith] 1308—ab
brucellosis causes, [Agin] 1312—ab
denial of, by patients, (Anton's syndrome), [Brockman] 889—ab
in congenital glaucoma, [Barkan] *530
National Society for Prevention of, (prize for paper on glaucoma) 258; (scholarships) 794
nutritional amblyopia in liberated prisoners, [Bloom] 62—ab
Seeing Eye Dog hoax, 191
BLISS, RAYMOND W., tribute to young physician by, 481—E
BLOOD: See also Medicolegal Abstracts at end of letter M
Bacteria in: See Meningococcemia
Banks: See Blood Transfusion
barbiturates in, estimation, 279
bilirubin in differentiating peptic ulcer from portal cirrhosis, [Navarro] 351—ab
bilirubin in intravenous liver extract therapy of cirrhosis, [Labby & others] *1184
calcium in multiple myeloma, [Bayrd & Heck] *153
carboxyhemoglobin concentration in aviators, [Pitts] 1304—ab
Cells: See also Erythrocytes; Leukocytes
cells (human, powdered) for ulcers of extremities, [Anderson] 885—ab
cells in late pregnancy and puerperium, 1254
cholesterol, diet for hypercholesteremia, 508
cholesterol, relation to cholesteroi content of aorta, [Faber] 653—ab
Circulation: See also Cardiovascular System
circulation, antitoxin in, in diphtheria, [Ipsen] 1243—ab
circulation time, parenteral vitamin B to determine, [Swenson] 424—ab
Clot: See Blood coagulation; Phlebothrombosis; Thrombophlebitis; Thrombosis
Clotting: See Blood coagulation
coagulant: penicillin, [Fradà] 354—ab; [Pelz] 800—C
Coagulation: See also Blood prothrombin
Coagulation, Anticoagulant: See also Dicumarol; Heparin
coagulation, anticoagulants and coronary thrombosis, 970
coagulation, anticoagulants effect on penicillin in endocarditis, [Priest] 427—ab
coagulation, changes after coronary thrombosis, [Ogura] 137—ab
coagulation, property of blood of hemophiliac, [Chevallier] 353—ab
cytotoxic factor in, in cancer, [Roskin] 1038—ab
Donor: See Blood Transfusion
Dyscrasia: See also Agranulocytosis, Acute; Anemia; Anemia, Pernicious; Erythroblastosis, Fetal; Leukemia; Polycythemia
dyscrasias, eye changes in, [Tassman] 1306—ab
Fibrin: See Fibrin
Flow: See Blood circulation
formation, folic acid panhematopoietic stimulus, [Doan] 128—ab
group reference laboratory, England, 566
group tests of newborn, [Davidsohn] 345—C
Groups O (Universal donors): See Blood Transfusion donor
Groups, Rh Factor: See Rh Factor
Hematology Research Foundation, 412
Hemoglobin: See Hemoglobin
in Feces: See Feces
in infectious mononucleosis, [Limarzi] 201—ab
in silicosis, [Helmann] 1244—ab
Infection: See Meningococcemia
Injection of Whole Blood or Its Derivatives: See Blood Transfusion
Loss: See Hemorrhage
maternal and fetal, oxygen pressure gradient between, [Barron] 207—ab
Menstrual: See Menstruation
Methemoglobin in: See Methemoglobinemia
penicillin levels, 145; (emulsions will prolong) [Putnam] 1174
phosphatase, estimation, [Herbert] 69—ab
phosphate, hyperphosphatemia in renal osteodystrophy, [Norman & others] *771
phosphorus and phosphatase in multiple myeloma, [Bayrd & Heck] *153
picture in late pregnancy and puerperium, 1254
Plasma: See under various headings of Blood; Blood Transfusion; Serum
BLOOD—Continued
Platelets: See Purpura, thrombopenic
potassium intoxication, [Finch] 61—ab
Preservation: See Blood Transfusion, blood banks
Preservative: See Blood Transfusion of plasma
pressor substance in renal hypertension, [Kreutzfeldt] 431—ab
Pressure: See BLOOD PRESSURE
proteins, hyperproteinemia, causes of, [Bayrd & Heck] *153
proteins in infectious hepatitis, [Armas-Cruz] 1247—ab; [Martin] 1315—ab
proteins in intravenous liver extract therapy of cirrhosis, [Labby & others] *1184
proteins (plasma), wound shock, [Stewart] *216
Prothrombin: See also Blood coagulation
prothrombin activity, methylxanthines effect on, [Rieben] 69—ab
prothrombin, hypoprothrombinemia refractory to vitamin K, [Snell] *1178
quinacrine, plasma concentrations, [Becker] 202—ab
sedimentation in multiple myeloma, [Bayrd & Heck] *151
sedimentation rate in brucellosis, 1254
Serum: See various subheads under Blood; Blood Transfusion; Serum
Spitting Up: See Hemoptysis
Sugar: See also Diabetes Mellitus
sugar, differential diagnosis of glycosuria, 278
sugar, hypoglycemia sequels, [Boulin] 1038—ab
sugar, hypoglycemia, taste and food selection in, [Mayer-Gross] 573—ab
Sugar, Hypoglycemic Shock (therapeutic): See Insulin shock
sugar, sucrose tolerance tests, [O'Brien & Higgins] 197—C
Supply: See Blood circulation
Tests: See Syphilis serodiagnosis
Thrombin: See Thrombin
Transfusion: See BLOOD TRANSFUSION
Universal: See Blood Transfusion
Urea: See also Uremia
urea nitrogen, low, 357
Volume: See also Blood circulation
volume data on severely wounded soldiers, [Stewart] *217
Vomiting of: See Hematemesis
BLOOD PRESSURE, age influence on, [Russek] 127—ab
flying at high altitude effect on, [Behnke] *450
high, American Foundation for, 117
high, antihistamine drugs and, 812
high, calcium intake and, [Kesson] 574—ab
high, cerebral hemorrhage and muscular exercise, 1320
high, cytral for, 1235
high, electrocardiogram in, [Filley] 270—ab
high, essential, renin in, [Taquini] 61—ab
high, Levy Foundation for research on, 490
high, malignant, [Selye] 64—ab
high malignant, pheochromocytoma of adrenal medulla cause of, [Washington] 724—ab
high, mannitol hexanitrate for, 1042
high, nephrectomy for, with unilateral renal disease, [Ratliff & others] *296
high, pitressin for, 898
high renal, pressor substance in blood, [Kreutzfeldt] 431—ab
high, salt and water metabolism disturbance in, [Perera] 499—ab
high, splanchnicectomy for, late results, [Fontaine] 429—ab
high, venesection for, 1253
in arms and legs, [Stewart] 424—ab
BLOOD TRANSFUSION, blood bank, American Red Cross program, 415; 945—OS
blood donor (dangerous universal), fatal use of, [Morgan] 805—ab
blood donor service (new), N. Y., 955
blood donor service (voluntary), 707
death in infant after, 811
donors, sex of recipients and, [Hustin] 1038—ab
for hemoglobinuric fevers (blackwater fever) in malaria, [Julliard] 729—ab
in management of wounds, [Snyder] *219
malaria transmitted by, danger, [Coggeshall] 1238—C
of plasma, toxicity of phenyl-mercuric borate used as preservative, 214
of plasma vs. whole blood in craniocerebral injuries, 214
surplus sets, sale of, 951
BLOOD VESSELS: See also Aorta; Arteries; Capillaries; Cardiovascular System; Veins
cholesterol deposition and atheromatosis, [Faber] 70—ab
Disease: See also Arteriosclerosis; Raynaud's Disease; Thromboangiitis obliterans; Varicose Veins
disease of brain stem and cerebellum, [Skoglund] 201—ab
disease (peripheral), inject 1 (—) histidine monohydrochloride-sodium ascorbate for, [Wirtschafter & Widmann] *604
disease, tetraethylammonium ion for, [Berry] 66—ab
BLOOD VESSELS—Continued
injuries influencing incidence of gangrene, [Thomas] 650—ab
intracranial, angiographic diagnosis, [List] 272—ab
sclerosis, sympathectomy for, [de Takats & Evoy] *441
surgery, Society for Vascular Surgery organized, 257
BLOODLETTING: See Venesection
BLOOMFIELD, JOHN J., temporary assignment in Bolivia, 488
BLUE CROSS: See Hospitals, expense insurance
BOARD: See also under specific names as American Board; Indiana Board; National Board; Specialties; State Board
of Health: See Health
of Roentgenology of Veterans Administration, [Birkelo & others] *359; 399—E
of Trustees: See American Medical Association
BOATS: See Ships
BOBBS, JOHN S., first operation for gallstones, 1905, [Fishbein] *683
BODY: See also Splanchnoptosis
Build: See Constitution
Dead: See Autopsies; Embalming
Growth of: See Growth
Heat Production: See Metabolism, basal
Lenin's, conservation, 1235
measurements in school health program, [Stuart] 719—ab
protection, restraining harness for aircraft pilots, [Bierman & others] *522
radium content, determine to prevent radium poisoning, [Hess] 1305—ab
Temperature: See Fever; Temperature, Body
Weight: See also Infants, Newborn; Obesity
weight, different responses to same provocation, [Johnson] 1238—C
weight, gain in pregnancy, relation to weight of newborn, [Klein] 129—ab
what is "normal"? 1011—E
BOECK'S Sarcoid: See Sarcoidosis
BOGOMOLETS, ALEXANDER, death; antireticular cytotoxic serum (ACS), 123
BOILS: See Carbuncle; Furunculosis
BONDS: See Investments
BONE MARROW: See also Myeloma; Osteomyelitis
Fibrosis of: See Osteosclerosis myelofibrosis
impairment by arsphenamine treatment, [Lachnit] 967—ab
in infectious mononucleosis, [Limarzi] 201—ab
medullary hypoplasia, [Alvarez] 1248—ab
BONES: See also Cartilage; Cranium; Joints; Orthopedics; Ribs; Osteitis; Osteo—; Spine
age determined by x-ray, [Dutton] 965—ab
Atrophy (Sudeck's): See Osteoporosis, posttraumatic
bank established, Pa., 1024
cancer metastatic from prostate, secondary myelofibrosis, [Bersack] 131—ab
chambers, ionization measurements with, [Stenstrom] 887—ab
Dislocation: See Dislocation (cross reference)
Dystrophy: See Osteodystrophy
eosinophilic granuloma, [Dundon] 273—ab; 1284—E
eosinophilic granuloma, role of allergy, 776—E
fetal, in bladder from ectopic pregnancy, [Forshaw] 429—ab
Fractures: See Fractures (cross reference)
grafts, reinforcement, [Carpenter] 849—ab
growth and vitamin A, [Mellanby] 1316—ab
lability of; mobilization of minerals and salts from skeleton, 110—E
skeleton changes in renal osteodystrophy, [Norman & others] *771
surgery, reconstruction of bony defects of face, [Macomber] 649—ab
surgery, subtrochanteric osteotomy in poliomyelitis, [Irwin] *231
tuberculosis (skeletal), lung lesions in, [Mann] 502—ab
tumors, primary sarcoma, [Shallow] 966—ab
BOOKS: See also Journals; Library; Book Notices at end of letter B
center for war devastated libraries, 878
medical (American), lack of in Italy, 644
removal of odor from, [Munkelt] 344—C
BORDEN Award: See Prizes
BOROWSKAJA method for colloidal gold liver function test, 734
BORRELIA vincenti: See Angina, Vincent's
BORTZ, EDWARD L., succeeds to A. M. A. presidency, 1012—E
BOTALLO'S DUCT: See Ductus arteriosus
BOTTLES: See Label
BOUILLAUD'S Disease: See Endocarditis
BOUTONNEUSE fever, differentiating from rickettsialpox, [Greenberg & others] *904
BOWDITCH, HENRY I., address, 1877, [Fishbein] *175
BOWEL Movement: See Feces
BOWELS: See Intestines
BOWMAN GRAY School, gifts to, 707
BOYS: See Adolescence
BRADY, WILLIAM, fallacies on pasteurization of milk, 249—E

BRAIN: See also Cerebellum; Cranium; Head; Nervous System
abscess, coccidioidal, [Rhoden] 723—ab
beriberi, [de Wardener] 1246—ab
concussion, diagnosis of postconcussional state, [Beck] 736—ab
concussion (mild), vertigo after; cause and treatment, 434
Disease: See also Epilepsy; Parkinsonism
disease, dynamite encephalosis, [Gerle] 142—ab
electroencephalogram in head injuries, [Laufer] 724—ab
electroencephalographers meet in Montreal, 337
electroencephalographic tracings, dysrhythmia in psychopaths, [Simon] 721—ab
electroencephalography in eclampsia, [Whitacre & others] *445
electroencephalography technicians needed, 113
Hemorrhage: See also Polioencephalitis, hemorrhagic
hemorrhage and muscular exertion, 1320
hemorrhage, sudden death in young men, 325—E; [Moritz] 721—ab
hemorrhage, treatment; brain surgery indicated? 214
Inflammation: See Encephalitis; Meningoencephalitis
Injury: See also Brain concussion; Cerebellum injury, late effects, 655
injury, war wounds of ventricles, [Pitts] 1240—ab
intracranial pneumograms, [Schneider] 650—ab
lesions, angiographic diagnosis, [List] 272—ab
mouse brain vaccine, treatment of epidemic encephalitis, [Sabin] *281
porencephaly, [Pendergrass] 130—ab
stem, vascular lesions of, [Skogland] 201—ab
surgery, bilateral frontal lobe leukotomy in mental disorders, [McKenzie] 134—ab
surgery, cortical excisions to relieve intractable pain, [Horrax] 273—ab
surgery in syringobulbia and syringopontia, [Cramer] 133—ab
surgery indicated in cerebral hemorrhage? 214
surgery, prefrontal leukotomy in mental disorders, results, England, 1234
surgery, prefontal leukotomy in 100 female patients, [Parker] 274—ab
surgery, psychosurgery for unbearable pain, [Watts] 891—ab
surgery, section of frontal lobe pathways in mental depression, [Van Wagenen] 273—ab
Syphilis: See Neurosyphilis
tissue extract action on staphylococcus infections, [Nuttall] 860—ab
Wounds: See Brain concussion; Brain injury
BRAISTED, WILLIAM C., A. M. A. president's address lasted 2½ hours, [Fishbein] *923
BRANCHIAL VESTIGES, primary cancer of neck, [Wiebderdink] 208—ab
BRAUN, WILL C., role in history of A. M. A., 1902-1904, [Fishbein] *605; *935
BREAD, lead intoxication from, 644
St. John's (powdered), in diet for diarrhea, [Rohmer] 729—ab
whole wheat, deleterious factor in, stimulates growth of pneumococcus, 491—E
BREAKFAST Foods: See Cereals Products
BREAST abscess, penicillin for, [Florey] 727—ab
cancer and ovarian hormone, 643
cancer, radiation for, [Kaplan] 1245—ab
Feeding: See Infants, feeding
inflammation (chronic cystic), treatment, 655
Inflammation (puerperal), penicillin for, [Taylor] 428—ab
Milk: See Milk, human
striae, diagnostic significance, 358
swelling (periodic), in men, 146
tumors, Brodie's disease [Aiken] 207—ab
tumors, sarcoma in women, [Brachetto-Brian] 1317—ab
BREATHING: See Respiration
BREEDING: See Eugenics
BRICK, fireproof, pneumonoconiosis in cutters of, 644
BRIDGE championships, doctor ties for third place, 788—OS
BRITISH: See also England; Royal; World War II
Anti-Lewisite: See BAL
Empire Cancer Campaign, (report on cancer research), 341; 566
Empire Rheumatism Council (10th anniversary), 52; (investigate cause of rheumatoid arthritis) 341
health and tuberculosis conference, 709
Journal of Nutrition: See Journals
Medical Association, (A. M. A. discusses establishment of *British Medical Journal* by, in 1840) [Fishbein] *236; *237; (conflict on National Health Service Act) 261; 419; 495; 643; 797; 880; (abstract periodicals from England) 480—E; (trouble in publishing their *Journal* in February, 1947) 698—E; 880
BRITISH—Continued
Medical Bulletin: See Journals
Medical Journal: See Journals
Medical Research Council: See Medical Research Council
National Health Service Act: See National Health Service Act
National Institute for Blind praises Helen Keller, 261
Troops: See World War II
BROADCASTING: See Radio
BRODIE'S Disease of breast, [Aiken] 207—ab
BROMIDE, mecholyl, toxicity, used as stimulant to smooth muscle of colon, 655
poisoning, transitory schizophrenias in, [Levin] 130—ab
BROMSULPHALEIN: See Sulfobromophthalein Sodium
BRONCHI: See Bronchus
BRONCHIAL Asthma: See Asthma
BRONCHIECTASIS, treatment, penicillin, [Harwood] 1172—ab
BRONCHITIS: See Laryngotracheobronchitis
Tuberculous: See Bronchus, tuberculosis
BRONCHUS, tracheobronchial drainage, 4 methods, [Foregger] *1200
tuberculosis, treatment, [Secretan] 430—ab
tumors, adenoma, lung resection, [Tricerri] 895—ab
tumors, adenomas, [Holley] 573—ab
BRONZE Star: See World War II, Heroes
BROUGHTON, J. M., address at National Conference on Rural Health, 866—ab
BROWN, CLARENCE J., U. S. Navy assignments, 488
BROWN Fat: See Fat
BRUCELLA abortus, transmission in milk, 1042
BRUCELLOSIS, blindness caused by, [Agin] 1312—ab
blood sedimentation rate affected by, 1254
chronic, [Moss] 135—ab
Inter-American Congress on, (1st), 118; (proceedings) 798
pregnancy and, 357
Puerto Rico, [Hernandez Morales] 204—ab
survey, Ind., 875
treatment, Castaneda vaccine (MBP), 656
BRUSSELL, JAMES A., personal, 790
BRUTALITIES in American psychiatric hospitals, [Wertham] 645—C
BUBONIC Plague: See Plague
BUCCAL Cavity: See Cheek
BUERGER'S Disease: See Thromboanglitis obliterans
BUFFALO Mineral Water, 422—BI
BUILDING: See also American Medical Association, headquarters; Home; Hospitals, building; Housing
skyscrapers, hygienic aspects, 1897, [Fishbein] *468
BULBOURETHRAL Glands (Cowper's), analogy of Bartholin's glands, [Movitt] 734
BUNIONS: See Toes, hallux valgus
BUNTING, C. H., revised Principles of Ethics, [Fishbein] *609; *611
BURDENKO, NIKOLAI, death, 52; 714
BUREAU of A. M. A.: See American Medical Bureau
BURNING Pain: See Causalgia
BURNS, chemical, nitrogen mustard gas (1149), [Uhde] 889—ab
chemical, of cornea, [McLaughlin] 719—ab
complications, anemia, [Moore] 426—ab
corneal and x-ray, sulfhydryl for, [Cruthirds] 131—ab
erythrocyte changes in severe type, [Brown] 1315—ab
pigmentation after boiling water splashed through a nylon stocking, 436
treatment, chemical debridement used by Cooper, Hodge and Beard, 811
treatment of shock with hypodermoclysis of hypertonic salt solution, [Berman] 348—ab
BURSITIS of shoulder, roentgen treatment, [Young] 500—ab
subacromial, [Olin] 1245—ab
BURTON-Hill Act: See Hill-Burton Act
BUSH, VANNEVAR, stable relations between government and research, 250—OS
BUTTER fat, value for growth, [Basu] 68—ab
food restriction vs. doctors order in esophagus cancer, 341
vitamin (new) in: vaccenic acid, 1299

BOOK NOTICES

Abderhalden, E., Lehrbuch der Physiologie in 33 Vorlesungen, 432
Abderhalden, R., Vitamine, Hormone, Fermente, 1173
Abdomen, Surgical Technic of Abdominal Operations, 576
Adolescence, Psychology of, 1040
Adventures of Jimmy Martin, Stowaway, 277
Albert-Weil, J., Les phénomènes d'allergie non spécifique dans la tuberculose et les fievres typhoide, 72
Allen, E. V., Peripheral Vascular Diseases, 575
Allen, R. B., Medical Education and the Changing Order, 1173
Book Notices—Continued
Allergy, 275
in Practice, 433
Les phenomenes d'allergie non specifique dans la tuberculose et les fievres typhoides, 72
What You Don't Know May Hurt You! 144
American Dietetic Association, Handbook of Diet Therapy, 275
American Hospital, 1173
American Philosophical Society, Symposia, 897
Anatomy: See also Pathology; Physiology
Human Ear in Anatomical Transparencies, 277
Illustrations of Regional Anatomy, 143
Principles of, for Physical Training Instructors in Royal Air Force, 1251
Anderes, E., Lehrbuch der Geburtshilfe und Gynäkologie, 653
Anderson, W. A. D., Synopsis of Pathology, 210
Andia, E. D., Liquido céfalo-raquídeo, L. C. R. 808
Anesthesia, Centennial of Surgical Anesthesia, 506
Conduction: Clinical Studies of George P. Pitkin, 808
Infiltrazione novocainica del plesso celiaco, 277
Memoir to Academy of Sciences at Paris on New Use of Sulphuric Ether, 506
Victory Over Pain: History of, 809
Ascorbic Acid Content of Blood, 897
Asthma, Diagnosis and Treatment, 505
Treatment of, 433
Astrophysique, 506
Ataxia, Heredopathia atactica polyneuritiformis, 1319
Atlas of Genitourina Pathology, 432
Bacteriology, Cultivation of Viruses and Rickettsiae, 1249
Bankoff, G., Operative Surgery, 1041
Basal Ganglia, Diseases of, 277
Behavior, Fundamental Patterns of Maladjustment, 355
Bell, E. T., Renal Diseases, 809
Benda, C. E., Mongolism and Cretinism, 575
Benedek, T., Insight and Personality Adjustment, 653
Berens, C., Diagnostic Examination of Eye: Step-by-Step Procedure, 276
Berg, R. H., Challenge of Polio: Crusade Against Infantile Paralysis, 211
Beveridge, W. I. B., Cultivation of Viruses and Rickettsiae in Chick Embryo, 1249
Biochemistry, Currents in Biochemical Research, 356
Laboratory Instructions in, 654
Textbook of, (Mitchell) 653; (Harrow) 1040
Biography: See Physicians
Blood, Astrophysique, 506
Ascorbic Acid Content, 897
Principles of Hematology, 506
Blood Pressure, Introduction to Essential Hypertension, 209
Renal Hypertension, 72
Blood Vessels, Peripheral Vascular Diseases, 575
Body Mechanics in Nursing Arts, 144
Bogert, L. J., Fundamentals of Chemistry, 897
Laboratory Manual of Chemistry, 897
Suggestions for Courses in General Chemistry, 896
Bone Marrow, La cultura in vitro del midollo osseo, 809
puncture, Principles of Hematology, 506
Bones, [Osteopetrosis and Normal Osteo- and Hematopoiesis], 576
Bonney, V., Technical Minutiae of Extended Myomectomy and Ovarian Cystectomy, 356
Boston City Hospital, Handbook of Neurological Examination and Case Recording, 576
Brain, Normal Encephalogram, 276
Braun-Menendez, E., Renal Hypertension, 72
Breakfast, Report of Better Breakfast Project Week, 277
British Information Services, Some Properties and Applications of DDT, 144
Brown, E. L., Use of Research by Professional Associations, 1251
Campbell, H., Maternity Homes for Unmarried Mothers, 355
Cancer, Autour du probleme du cancer, 277
Experimentelle Grundlagen zu einer modernen Pathologie, 1251
of Scrotum in Relation to Occupation, 72
Royal Cancer Hospital Mechanically Sorted Punched Card Index System, 897
X-Ray Treatment of Accessible Cancer, 1249
Carbohydrate Metabolism, 575
Cardiology: See Heart
Cardiovascular Disease in General Practice, 355
Cardiovascular System: See Blood Vessels; Heart
Carr, M. W., Dentistry: Agency of Health Service, 506
Case Recording, Handbook for Neurological Examination and, 576
Casts, Plaster of Paris Technique, 969
Celiac Plexus, Infiltrazione novocainica del plesso celiaco, 277
Cells, Experimentelle Grundlagen zu einer modernen Pathologie, 1251

Book Notices—Continued
Cerebrospinal Fluid, Líquido céfalo-raquídeo L.C.R., 808
Chemistry: See also Biochemistry; Drugs; Pharmacology
Fundamentals of, 897
Laboratory Manual of, 897
Suggestions for Courses in, 896
Chemotherapy, Modern Development of, 209
Chest: Handbook of Roentgen Diagnosis, 432
Children: See also Pediatrics
Child from Five to Ten, 505
Fundamental Patterns of Maladjustment, 355
Monocular Vision Training, 808
Personality of Preschool Child: Child's Search for His Self, 969
Cincinnati, Report of Better Breakfast Project Week, 277
Clark, R. C., Threescore Years and Ten: Eli Lilly and Co., 1876-1946, 277
Clinical: See Diagnosis
Commonwealth Fund, Psychotherapy in General Medicine, 654
Corwin, E. H. L., American Hospital, 1173
Cretinism and Mongolism, 575
Cushing, Harvey: Biography, 143
Cushny, A. B., Pharmacology and Therapeutics, 1250
Cutting, W. C., Actions and Uses of Drugs, 275
Cyclopedia: See Atlas; Dictionary; Encyclopedia
DDT, Some Properties and Applications of, 144
Davidoff, L. M., Normal Encephalogram, 276
Davis, L., Principles of Neurological Surgery, 808
Deaf-mutism, Etiology of, with Special Reference to Heredity, 356
Denny-Brown, D., Diseases of Basal Ganglia and Subthalamic Nuclei, 277
Handbook of Neurological Examination and Case Recording, 576
Dentistry: Agency of Health Service, 506
Oral Diagnosis and Treatment, 1041
Psychobiologic Foundations in, 732
Derbes, V. J., Treatment of Bronchial Asthma, 433
Dermatology, Practical Handbook of Pathology of Skin, 1319
X-Rays and Radium in Treatment of Diseases of Skin, 144
Diabetes Mellitus, Diabetic Care in Pictures, 807
Primer for Patients, 576
Diagnosis, Diagnostic Examination of Eye: Step-by-Step Procedure, 276
Diagnostic Psychological Testing, 71
Dictionary: See also Encyclopedia
Spanish-English Medical, 808
Stedman's Practical Medical, 275
Dierckx, K., [Osteopetrosis and Normal Osteo- and Hematopoiesis] 576
Diet: See also Food; Nutrition; Vitamins
Handbook of Diet Therapy, 275
Doctor: See Physicians
Drugs: See also Chemistry; Pharmacology; Pharmacy
Actions and Uses of, Textbook for Nurses, 275
Formulary, University Hospital, Ann Arbor, Michigan, 1173
Modern Drug Encyclopedia and Therapeutic Index, 210
National Formulary, 896
Threescore Years and Ten: First Seventy Years of Eli Lilly and Co. 1876-1946, 277
Ducuing, J., Le fibro-myome uterin, 654
Ear: See Otology
East, T., Cardiovascular Disease in General Practice, 355
Economic Aspects of National Health Activities, 897
Education, Medical Education and the Changing Order, 1173
Nature and Conditions of Learning, 969
Electrocardiography: See Heart
Embryology, Human, 731
Embryonal Tissues, Stimulation of Healing, 896
Encyclopedia: See also Atlas; Dictionary
Modern Drug, 210
of Psychology, 505
Popular Medical, 211
Enzymes, Vitamine, Hormone, Fermente, 1173
Epilepsy, L'epilessia sperimentale, 654
Erwin, G. S., Guide for Tuberculous Patient, 1040
Evans, M. S., Monocular Vision Training, 808
Eyes: See Ophthalmology
Face, Etiology of Congenital Clefts of, 276
Family problems, Frank Discussions of, If You Ask My Advice, 72
Fash, B., Body Mechanics in Nursing Arts, 144
Favill, J., Outline of Spinal Nerves, 897
Feinberg, S. M., Allergy in Practice, 433
Fenichel, O., Psychoanalytic Theory of Neuroses, 71
Fibromyomas, Le fibro-myoma utérin, 654
Fiction, Adventures of Jimmy Martin, Stowaway, 277
Doctor Destiny, 277
Fieschi, dlA., La cultura in vitro del midollo osseo, 809
Fishbein, M., editor, Bibliography of Infantile Paralysis, 1789-1944, 355
editor, Popular Medical Encyclopedia, 211
Fleisch, A., Ernahrungsprobleme in Mangelzeiten: Die schweizerische Kreigsernahrung 1939-1946, 1250
Fogh-Andersen, P., Inheritance of Harelip and Cleft Palate, 276
Food: See also Diet; Nutrition; Vitamins
Report of Better Breakfast Project Week, 277
Formulary, National, 896
University Hospital, Ann Arbor, Mich., 1173
Foundation: See Menninger Foundation; National Foundation
Fractures, Plaster of Paris Technique in Treatment of, 969
Francke, D. E., Formulary, University Hospital, Ann Arbor, Mich., 1173
Friedenwald, H., Jewish Luminaries in Medical History, 807
Friedman, N. B., Atlas of Genitourinary Pathology, 432
Frogs, Xenopus Laevis: Bibliography, 277
Frolh, G., Astrophysique, 506
Fulton, J. F., Centennial of Surgical Anesthesia, 506
Harvey Cushing: A Biography, 143
Garrison, K. C., Psychology of Adolescence, 1040
Gay, L. N., Diagnosis and Treatment of Bronchial Asthma, 505
Genetics: See Heredity
Genitourinary Pathology, Atlas of, 432
Geriatrics: See Old Age
Gesell, A., Child from Five to Ten, 505
Gilmour, W. S., Tuberculosis in West Indies, 356
Goldberga, D. I., Stimulation of Healing of Wounds and Ulcer Processes, 896
Gonorrhea, Public Health Nursing in, 211
Grawitz, P. B., Experimentelle Grundlagen zu einer modernen Pathologie, 1251
Green, D. E., editor, Currents in Biochemical Research, 356
Grollman, A., Pharmacology and Therapeutics, 1250
Guiman, A. B., editor, Modern Drug Encyclopedia and Therapeutic Index, 210
Gynecology, Essentials of, 732
Lehrbuch der Geburtshilfe und Gynäkologie, 653
Operative, 807
Practical Handbook of, 506
Haden, R. L., Principles of Hematology, 506
Hagtvet, J., Ascorbic Acid Content of Blood, 897
Harelip, Inheritance of, 276
Harriman, P. L., editor, Encyclopedia of Psychology, 505
Harris, R. S., editor, Vitamins and Hormones, 1251
Harrow, B., Textbook of Biochemistry, 1040
Haultain, W. F. T., Practical Handbook of Midwifery and Gynecology, 506
Havinga, E., Modern Development of Chemotherapy, 209
Health: See also Hygiene; Mental Hygiene
Dentistry: Agency of Health Service, 506
Public Health Nursing in Syphilis and Gonorrhea, 211
Symposia on Present Day Social and Economic Aspects of National Health, 897
Heart: See also Cardiovascular Disease
Electrocardiographic Interpretation, Exercises in, 654
Estudio critico del tratamiento medico de la insuficiencia cardiaca, 211
Hekteen, L., Bibliography of Infantile Paralysis, 1789-1944, 355
Held, I. W., Peptic Ulcer: Diagnosis and Treatment, 1249
Hematology: See Blood
Henry, S. A., Cancer of Scrotum in Relation to Occupation, 72
Heredity, Etiology of Deaf-Mutism with Special Reference to, 356
Heredopathia atactica polyneuritiformis, 1319
Inheritance of Harelip and Cleft Palate, 276
Herndon, R. F., Introduction to Essential Hypertension, 209
Hewitt, L. E., Fundamental Patterns of Maladjustment, 355
Hingson, R. A., editor, Conduction Anesthesia, 808
Histology, Experimentelle Grundlagen zu einer modernen Pathologie, 1251
Holmes, G., Introduction to Clinical Neurology, 277
Hormones and Vitamins: Advances in Research and Applications, 1251
Vitamine, Hormone, Fermente, 1173
Horney, K., editor, Are You Considering Psychoanalysis, 732; (correction) 957
Hospital, American, 1173
Boston City, Handbook of Neurological Examination and Case Recording, 576
Mount Sinai, Manual of Nursing Procedures, 210
Hospital—Continued
Organization and Management, 1173
Royal Cancer, Mechanically Sorted Punched Card Index System, 897
University, Ann Arbor, Michigan, Formulary, 1173
Hunterian Lecture, Cancer of Scrotum in Relation to Occupation, 72
Hygiene: See also Health
Textbook for College Students, 1040
Hyman, H. T., Integrated Practice of Medicine, 1039
Hypertension: See Blood Pressure
If You Ask My Advice, 72
Illegitimacy, Maternity Homes for Unmarried Mothers: Community Service, 355
Illustrations of Regional Anatomy, 143
Industry, Cancer of Scrotum in Relation to Occupations, 72
Infants: See Children; Pediatrics
Infra-Red Rays, Applications of, 896
Insight and Personality Adjustment, 653
Jamieson, E. B., Illustrations of Regional Anatomy, 143
Janjigian, E. R., Doctor Destiny, 277
Jenkins, R. L., Fundamental Patterns of Maladjustment, 355
Jewish Luminaries in Medical History, 807
Katz, L. N., Exercises in Electrocardiographic Interpretation, 654
Kidney, Artificial, 209
Renal Diseases, 809
Renal Hypertension, 72
Zur Physio-Pathologie der Niere, 72
Kingsley, H. L., Nature and Conditions of Learning, 969
Kitching, R., Sex Problems of Returned Veteran, 211
Kleiner, I. S., Laboratory Instructions in Biochemistry, 654
Kolff, W. J., Artificial Kidney, 209
Labor: See Obstetrics
Laboratory Instructions in Biochemistry, 654
Lecture: See Hunterian Lecture
Leprosy, 731
Leriche, R., Thromboses artérielles, 144
Lillingston, C., translator, Heredopathia atactica polyneuritiformis, 1319
Lilly, Eli, and Co., Threescore Years and Ten, 277
Lindenov, H., Etiology of Deaf-Mutism with Special Reference to Heredity, 356
Lucklesh, M., Applications of Germicidal, Erythemal and Infrared Energy, 896
McCartney, J. L., Drama of Sex, 276
MacEachern, M. T., Hospital Organization and Management, 1173
McElligott, M., Spanish-English Medical Dictionary, 808
MacKee, G. M., X-Rays and Radium in Treatment of Diseases of the Skin, 144
MacLeod, J. M. H., Practical Handbook of Pathology of Skin, 1319
Malariology, Practical, 1041
Marriage, Sex, and Family, 210
Maternity Homes for Unmarried Mothers: Community Service, 355
Medical Education: See Education
Medical History, Centennial of Surgical Anesthesia, 506
Jewish Luminaries in, 807
Memoir to Academy of Sciences at Paris on New Use of Sulphuric Ether, 506
Victory Over Pain: History of Anesthesia, 809
Medical Research: Symposium, 809
Medical Research Council, Cultivation of Viruses and Rickettsiae, 1249
Medical Social Service in Tuberculosis Control, 896
Medicine: See also Medical History; Physicians; Surgeons; Surgery; etc.
Integrated Practice of, 1039
Popular Medical Encyclopedia, 211
Menninger Foundation, Diagnostic Psychological Testing, 71
Mental Hygiene, Hygiene: Textbook for College Students, 1040
Symposium on National Health, 897
Toward Mental Health, 211
Merritt, H. H., Neurosyphilis, 1319
Meredith, F. L., Hygiene: Textbook for College Students, 1040
Michigan Child Guidance Institute, Fundamental Patterns of Maladjustment, 355
Midwifery: See Obstetrics
Military: See War
Miller, S. C., Oral Diagnosis and Treatment, 1041
Mitchell, P. H., Textbook of Biochemistry, 653
Mitchell-Nelson Textbook of Pediatrics, 276
Mola, B., Estudio critico del tratamiento medico de la insuficiencia cardiaca, 211
Mondor, H., Pasteur, 1041
Mongolism and Cretinism, 575
Montpellier, J. M., Autour du probleme du cancer, 277
Morlock, M., Maternity Homes for Unmarried Mothers, 355
Morris E. H., Public Health Nursing in Syphilis and Gonorrhea, 211

Book Notices—Continued
Morton, W. T. G., Memoir to Academy of Sciences at Paris on New Use of Sulphuric Ether, 506
Moruzzi, G., L'epilessia sperimentale, 654
Mount Sinai Hospital Manual of Nursing Procedures, 210
Mouth, Oral Diagnosis and Treatment, 1041
Muir, E., Leprosy, 731
Myomectomy, Extended, Technical Minutiae of, 356
National Formulary, 896
National Foundation for Infantile Paralysis, Bibliography, 1789-1944, 355
Challenge of Polio: Crusade Against Infantile Paralysis, 211
Nelson, W. E., editor, Textbook of Pediatrics (Mitchell-Nelson), 276
Nephritis, Die interstitielle Nephritis, 211
Nerves: See Neurology
Neurology, Clinical Introduction to, 277
Clinical, Textbook of, 432
Die periphere Innervation, 732
Diseases of Basal Ganglia and Subthalamic Nuclei, 277
Handbook of Neurological Examination and Case Recording, 576
Heredopathia atactica polyneuritiformis, 1319
Liquido céfalo-raquídeo, L.C.R.,808
Normal Encephalogram, 276
Outline of Spinal Nerves, 897
Neurosis, Psychoanalytic Theory of, 71
Neurosurgery, Principles of Neurological Surgery, 808
Neurosyphilis, 1319
New York Academy, American Hospital, 1173
Medical Education and the Changing Order, 1173
Nielsen, J. M., Textbook of Clinical Neurology, 432
Nightingale, F., Notes on Nursing: What It Is, and What It Is not. (facsimile of first edition, 1859-1860), 276
Novels: See Fiction
Nursing, Actions and Uses of Drugs, 275
Body Mechanics in Nursing Arts, 144
Manual of Nursing Procedures, Mount Sinai Hospital, New York City, 210
Notes on Nursing: What It Is, and What It Is not (Nightingale's), 276
Public Health Nursing in Syphilis and Gonorrhea, 211
Nutrition: See also Diet; Food; Vitamins
Experiences of Switzerland, 1939-1946, Ernahrungsprobleme in Mangelzeiten, 1250
Obstetrics, Essentials of, 732
Practical Handbook of, 506
Occupations: See Industry
Ohio, Report of Better Breakfast Project Week of Jan. 14, 1946, 277
Old Age, Care of the Aged, 143
Second Forty Years, 808
Ophthalmology, Diagnostic Examination of the Eye: Step-by-Step Procedure, 276
Les yeux et la vision des vertebres, 433
Monocular Vision Training, 808
Ocular Prosthesis, 807
Oral Diagnosis and Treatment, 1041
Orgel, S. Z., Psychiatry Today and Tomorrow, 432
Orthopedics, Plaster of Paris Technique, 969
Osteopetrosis and Normal Osteo- and Hematopoiesis, 576
Otology, Human Ear in Anatomical Transparencies, 277
Ovary, Technical Minutiae of Ovarian Cystectomy, 356
Pain, Victory Over Pain: History of Anesthesia, 809
Palate, cleft, Inheritance of, 276
Pasteur, Louis, 1041
Pathology, Experimentelle Grundlagen zu einer modernen Pathologie, 1251
Genitourinary, Atlas of, 432
Practical Handbook of Pathology of Skin, 1319
Synopsis of, 210
Patten, B. M., Human Embryology, 731
Pediatrics: See also Children
Textbook of (Mitchell-Nelson), 276
Peptic Ulcer: Diagnosis and Treatment, 1249
Personality Adjustment, Insight and, 653
of Preschool Child, 969
Pharmacology: See also Chemistry; Drugs; Pharmacy
Cushny's Pharmacology and Therapeutics, 1250
Pharmacy's Part in Society, 1319
Physical Training Instructors in Royal Air Force, Anatomy and Physiology for, 1251
Physicians: See also Medicine; Surgery
biography: Harvey Cushing, 143
biography, Pasteur, 1041
Doctor Destiny, 277
Jewish Luminaries in Medical History, 807
Physiology: See also Anatomy
Lehrbuch der Physiologie in 33 Vorlesungen, 432
Principles of, for Physical Training Instructors in Royal Air Force, 1251
Zur Physio-Pathologie der Niere, 72
Pitkin, George P., Conduction Anesthesia, 808
Pleasants, H., Jr., If You Ask My Advice, 72
Poliomyelitis, Bibliography of Infantile Paralysis, 1789-1944, 355
Challenge of Polio: Crusade Against Infantile Paralysis, 211
Polowe, D., Adventures of Jimmy Martin, Stowaway, 277
Polyak, S. L., Human Ear in Anatomical Transparencies, 277
Popular Medical Encyclopedia, 211
Pregnancy, Xenopus Laevis: Bibliography, 277
Prince, J. H., Ocular Prosthesis, 807
Procaine, Infiltrazione novocainica del plesso celiaco, 277
Professional Associations, Use of Research in Determining Program and Policy, 1251
Prosthesis, Ocular, 807
Psychiatry: See also Behavior; Mental Hygiene; Neurosis; Psychoanalysis; Psychology; Psychotherapy
Today and Tomorrow, 432
Psychoanalysis, Are You Considering? 732; (correction), 957
Theory of Neurosis, 71
Psychobiologic Foundations in Dentistry, 732
Psychology: See also Behavior; Psychoanalysis, Diagnostic Psychological Testing, 71
educational, Nature and Conditions of Learning, 969
Encyclopedia of, 505
Insight and Personality Adjustment: Study of Effects of War, 653
of Adolescence, 1040
Psychotherapy in General Medicine: Report of an Experimental Postgraduate Course, 654
Public Health: See Health
Quigley, T. B., Plaster of Paris Technique, 969
Radiography: See Roentgenology
Radium in Treatment of Diseases of the Skin, 144
Rapaport, D., Diagnostic Psychological Testing, 71
Refsum, S., Heredopathia atactica polyneuritiformis, 1319
Rehabilitation and Convalescence, American Philosophical Society symposia, 897
Proceedings Conference on, of Tuberculous, 576
Research, Medical Research: Symposium, 809
Use of, by Professional Associations in Determining Program and Policy, 1251
Rice, T. B., Sex, Marriage and Family, 210
Rickettsiae, Cultivation of, in Chick Embryo, 1249
Rigler, L. G., Chest: Handbook of Roentgen Diagnosis, 432
Robinson, V., Victory Over Pain: History of Anesthesia, 809
Rochon-Duvigneaud, A., Les yeux et la vision des vertebres, 433
Roentgenology, Chest: Handbook of Roentgen Diagnosis, 432
Handbook of Radiography, 72
Principles in Roentgen Study of the Chest, 1251
X-Ray Treatment of Accessible Cancer, 1249
X-Rays in Treatment of Diseases of Skin, 144
Rogers, L., Leprosy, 731
Rosenthal, H., Diabetic Care in Pictures, 807
Ross, J. A., Handbook of Radiography, 72
Rossi, A., Infiltrazione novocainica del plesso celiaco, 277
Royal Air Force, Principles of Anatomy and Physiology for Physical Training Instructors in, 1251
Royal Cancer Hospital Mechanically Sorted Punched Card Index System, 897
Rudolph, J. A., What You Don't Know May Hurt You! 144
Russell, P. F., Practical Malariology, 1041
Ryan, E. J., Psychobiologic Foundation in Dentistry, 732
Sanitation: See Health; Hygiene
Sapelkin, N., Xenopus Laevis: Bibliography, 277
Scoliosis: Practical Approach to Treatment, 1250
Scott, W. A., Essentials of Obstetrics and Gynecology, 732
Second Forty Years, 808
Sex, Drama of, 276
Marriage and Family, 210
Skin: See Dermatology
Slaughter, F. G., New Science of Surgery, 276
Smith, A., editor, Medical Research: Symposium, 809
Smith, G., Psychotherapy in General Medicine, 654
Smithers, D. W., X-Ray Treatment of Accessible Cancer, 1249
Snow, W., Principles in Roentgen Study of Chest, 1251
Social Service (Medical) in Tuberculosis Control, 896
Symposia on National Health, 897
Societies, Use of Research in Determining Policy and Program, 1251
Soskin, S., Carbohydrate Metabolism, 575
Southworth, J. L., editor, Conduction Anesthesia, 808
Spanish-English Medical Dictionary, 808
Spine, Scoliosis: Practical Approach to Treatment, 1250
Spivack, J. L., Surgical Technic of Abdominal Operations, 576
Spühler, O., Zur Physio-Pathologie der Niere, 72
Stedman's Practical Medical Dictionary, 275
Stieglitz, E. J., Second Forty Years, 808
Surgery, New Science of, 276
Operative Gynecology, 807
Operative Surgery, 1041
Principles of Neurological Surgery, 808
Surgical Technic of Abdominal Operations, 576
Technical Minutiae of Extended Myomectomy and Ovarian Cystectomy, 356
Sweany, H. C., editor, Guide for Tuberculous Patient, 1040
Switzerland, nutritional experiences, 1939-1946, Ernahrungsprobleme in Mangelzeiten, 1250
Syphilis, Public Health Nursing in, 211
Taylor, N. B., editor, Stedman's Practical Medical Dictionary, 275
Teeth: See Dentistry
Te Linde, R. W., Operative Gynecology, 807
Therapeutics, Modern Drug Encyclopedia and Therapeutic Index, 210
Pharmacology and, Cushny's, 1250
Thewlis, M. W., Care of the Aged (Geriatrics), 143
Thorax, Chest: Handbook of Roentgen Diagnosis, 432
Principles of Roentgen Study of Chest, 1251
Thorman, G., Toward Mental Health, 211
Thromboses artérielles, 144
Treatment: See Therapeutics
Tuberculosis, Guide for Tuberculous Patient, 1040
in West Indies, 356
Les phenomenes d'allergie, 72
Medical Social Service in Tuberculosis Control, 896
Proceedings Conference on Rehabilitation of Tuberculous, 576
Tumors: See also Cancer
Le fibro-myoma utérin, 654
Turner, D., Handbook of Diet Therapy, 275
Typhoid, Les phenomenes d'allergie, 72
Ulcer Processes, Stimulating of Healing of, 896
United Nations, Educational, Scientific and Cultural Organization, 897
University Hospital, Ann Arbor, Michigan, Formulary, 1173
of Minnesota, Psychotherapy in General Medicine, 654
Urbach, E., Allergy, 275
Urdang, G., Pharmacy's Part in Society, 1319
Uterus, Le fibro-myoma, 654
Technical Minutiae of Extended Myomectomy, 356
Venereal Disease: See also Gonorrhea; Syphilis
Control of, 210
Veterans, Sex Problems of Returned Veteran, 211
Victory Over Pain: History of Anesthesia, 809
Villiger, E., Die periphere Innervation, 732
Viruses, Cultivation of, in Chick Embryo, 1249
Vision: See Ophthalmology
Vitamins and Hormones: Advances in Research and Applications, 1251
Vitamine, Homone, Fermente, 1173
Vonderlehr, R. A., Control of Venereal Disease, 210
War: See also Veterans
Anatomy and Physiology for Physical Training Instructors in Royal Air Force, 1251
Insight and Personality Adjustment: Study of Psychological Effects of War, 653
West Indies, Tuberculosis in, 356
What You Don't Know May Hurt You! 144
Wilder, R. M., Primer for Diabetic Patients, 576
Wolff, W., Personality of Preschool Child: Child's Search for His Self, 969
Woodcock, B., Scoliosis: Practical Approach to Treatment, 1250
Wounds, Stimulation of Healing of, 896
Xenopus Laevis: Bibliography, 277
Yale Clinic, Child from Five to Ten, 505
Zollinger, H. U., Die interstitielle Nephritis, 211
Zwarenstein, H., Xenopus Laevis: Bibliography, 277

C

CADAVERS: See Autopsies; Embalming
CADMIUM lined containers for foods and drinks, danger of, [Monnet] 729—ab
CAFFEINE: See also Coffee
reproductivity of rats given, [Bachmann] 202—ab
CAIN, ROLLY M., death of president of Abbott Laboratories, 706
CAISSON DISEASE, decompression sickness, [Burkhardt & others] *373
CALCIFICATION: See Bones, growth; Lungs; Spleen
CALCIUM, animal feeds should contain, 775—E
ascorbate treatment of myasthenia gravis, 1252
in Blood: See Blood
in body fluids, reducing, 1043
intake and hypertension, [Kesson] 574—ab
levulinate, N.N.R., [Hartz] 543

CALCIUM—Continued
metabolism disorder in renal osteodystrophy, [Norman & others] ★771
metabolism, effect of oxalates on, 1010—E
treatment of lupus vulgaris, [Hermans] 504—ab
CALCULI: See Bile Ducts; Gallbladder; Pancreas
CALIFORNIA cancer program, 412
Medical Association, promote good public relations, [various authors] 628—ab
Society of Internal Medicine organized, 636
Spanish moss, antibiotic from, [Marshak] 1245—ab
University of: See University
CALORIES, intake and industrial output, 322—E
number required by farm animals compared with man, 775—E
CAL-PAR, Dr. Parrish's frauds, 57—BI
CAMBRIDGE University: See University of Cambridge
CAMPS, Prison: See World War II Trailer: See Automobiles
CANADIAN Army: See Army
CANCER: See also under name of organ or region affected; Medicolegal Abstracts at end of letter M
adenomas relation to, [Helwig] 1313—ab
American Cancer Society (clinics inspection by American College of Surgeons), 132: 1092; 133: 38
A. M. A. committee, 1913, [Fishbein] ★770
British Empire Cancer Campaign report, 341; 566
Clinics: See also Cancer control clinics, (N. Y.) 562; (Kan.) 792
clinics (consultative) opened, Conn., 1227
control, detection centers (10) to open at once, N. Y. C., 491
control, detection clinic (free, New York), 256; (Ky.) 706
control, diagnostic clinic (Illinois), 115; 636
control, federal funds for, A. M. A. motion on dispersal, 40
control month, April, 1165
control, prevention clinic, D. C., 185—OS
control program, (Cal.) 412; (Md.) 955
control programs, USPHS annual report, 702
control, survey of patients, D. C., 871—OS; 948—OS
control, survey to be conducted, U.S.P.H.S., 482—OS
control under Taft-Smith-Ball-Donnell Bill, 869—OS
cytotoxic factor in blood of patients, [Roskin] 1038—ab
day (annual) Mich., 562
Diagnosis: See also Cancer control diagnosis, vaginal smear, [Meigs] ★75
eosinophilia in, [Isaacson] 1171—ab
etiology, 20-methylcholanthrene, what dose to produce skin cancer in mice? 435
hospital construction begins, N. Y., 414
hospital, proposed in Chicago by Veterans Administration, 253
Hoxsey—charlatan, 774—E; (correction) 957
Information centers, W. Va., 492
metastases of cells through respiratory passages, [Furth] 268—ab
metastases to bone from prostate, [Bersack] 131—ab
mortality, decrease in women, 1025
National Advisory Cancer Council, (Gastric Cancer Committee conference), 187; (membership) 790
National Cancer Institute, Canada, 1231
National Cancer Institute, U. S., 631—OS
patients, home care for, N. Y., 335
Prevention: See Cancer control
prize essay contest by West Virginia Cancer Society, 415
Public Health Cancer Association of America, 192
recurrence in cervix 18 years after radium therapy, [Covington] ★935
refresher courses, Calif., 49
registry, establish, Kans., 1292
registry of chorionepithelioma, gift from Dr. Albert W. Bolman, 192
research, (Ind.) 115; (funds allotted, W. Va.) 116; (bills in Congress concerning) 328—OS; (in England) 341; 566; (grant to U. of California) 636; (at Washington U.) 876
research grants from Childs Memorial Fund, 1231
symposium, (Ill.) 255; (Wis.) 956
teaching day, N. Y., 256
treatment, autovaccination (Besredka-Krasnenitsky), 111—E; [Gross] 800—C
treatment, betatrons, proposed erection of, 556—OS
treatment, Chaoul's near distance roentgen therapy, [Arho] 142—ab
treatment, facilities for care of advanced patients, 955
treatment, from Russia, 2 methods, 111—E
treatment, KK, cancerolytic agent of Trypanosoma crusi, 111—E; 122; [Gross] 800—C; [Klyueva] 1038—ab
treatment, male hormone, 734
treatment, mechanism of radiation, Barnard Hospital lecture, [Warren] ★462
CANCER—Continued
treatment, radiation, [Kaplan] 1245—ab
treatment, tests of new chemical compounds at National Cancer Institute, 631—OS
week, N. J., 876
CANICOLA Fever: See Leptospirosis canicola
CAPILLARIES: See also Telangiectasia
resistance and vitamin P, [Galmiche] 141—ab
CAPPS Prize: See Prizes
CARBAMIDE: See Urea
CARBARSONE treatment of amebiasis, 1042
CAR-BO-AK, 883—BI
CARBOHYDRATES: See also Dextrose; Lactose; Sugar
diet high in, and thiamine deficiency, [Ring] 1304—ab
diet high in, effect on bends, chokes, etc. [Burkhardt & others] ★374; ★376
diet rich in, migraine produced by, (reply) [Foldes] 280
CARBON: See also Charcoal
activated, to remove odor from books, [Munkelt] 344—C
CARBON DIOXIDE inhalation for hiccup, 810
tension (alveolar), and decompression sickness, [Hodes] 719—ab
CARBON MONOXIDE, blood concentrations in airplane pilots, [Pitts] 1304—ab
poisoning (acute), Paris district, 55
poisoning, nervous system lesions in, [Lhermitte] 806—ab
uptake in high altitude flight, relation to lung ventilation, [Behnke] ★454
CARBON TETRACHLORIDE, liver injury from, methionine for (Council report), 107
treatment of fasciolopsis infection, 900
4'CARBOXYPHENYLMETHANESULFONANILIDE: See Caronamide
CARBUNCLE: See also Furunculosis
treatment, bacitracin, [Meleney & Johnson] ★677
CARCINOGENS: See Cancer etiology
CARCOMA: See Cancer
CARDANO, GIROLAMO, autobiography, 749—ab
CARDIAC: See Heart
Muscle: See Myocardium
Neurosis: See Asthenia, neurocirculatory
CARDIALGIA: See Heartburn
CARDIOVASCULAR DISEASE: See Blood Vessels disease; Heart disease
Hypertensive: See Blood Pressure, high
CARDIOVASCULAR SYSTEM: See also Arteries; Blood Vessels; Capillaries; Heart; Veins
abnormal communications, diagnosis by catheterization, [Geiger] 125—ab
congenital defects, surgical treatment, 248—E
sounds, phonograph recordings, [Stokes] 429—ab
CARDS: See Bridge
CARIES: See Teeth
CARONAMIDE, new drug inhibits excretion of penicillin, 1294
CAROTID SINUS syndrome (correction) 192
CARPUS: See Wrist
CARRIERS: See Disease carriers (cross reference)
CARROTS, diet of, plus St. John's Bread for diarrhea, [Rohmer] 729—ab
CARS: See Automobiles
CARSTENS, J. H., answers New York Medical Record attacks on A. M. A. in 1906 [Fishbein] ★685; ★686
CARTILAGE, grafts (composite free), [Brown] 720—ab
CARTOON: See American Medical Association, Council on Pharmacy and Chemistry
CASE Finding: See Tuberculosis
Records: See Medical Record Librarian
CASEIN, Hydrolysate of: See Amigen
CAST, local use of ice after, [Schaubel] 269—ab
CASTANEDA, GONZALO, death, 492
CASTANEDA Vaccine: See Brucellosis
CASUALTIES: See Accidents; World War II casualties
CATARACT surgery in patient with head tremor, 278
CATGUT, chronic, vs. cotton sutures, [Stevens] 891—ab
CATHARTICS, Corley's nostrums, 422—BI
Helping Hand Laxative Tonic, 883—BI
CATHETER plus vaginal diaphragm to control urinary incontinence, [Castallo] ★244
tracheobronchial drainage, [Foregger] ★1200
CATHETERIZATION, cardiovascular, [Geiger] 125—ab
CATTLE: See also Cows
fluorosis in, as industrial hazards, [Murray] 728—ab
Q fever in U. S., [Topping & others] ★813; [Irons & Hooper] ★815; [Irons & others] ★819; [Cox & others] ★820
CAUDA equina, tumors, lipoma, [Furtado] 208—ab
CAUDAL Anesthesia: See Anesthesia
CAUSALGIA; treatment, [Zikeyev] 431—ab
treatment, inject tetraethylammonium ion, [Berry] 66—ab
treatment, surgical, [Ulmer] 650—ab
CAVAL Veins: See Vena cava
CAVITIES, Dental: See Teeth caries
CECUM, amebic disease, [Wilbur] 1171—ab
CELLOPHANE wrapping of patent ductus arteriosus, [Poppe] 204—ab
CELLS: See also Blood cells; Tissues
argentaffin, in pancreatic islet cell tumors, [Hultquist] 730—ab
Chromaffin: See Pheochromocytoma
recovery after penicillin treatment in endocarditis, [Moore] 724—ab
CENTRAL Health Council for National Health Service, England, 880
CEPHALIN-cholesterol liver function test, [Mateer & others] ★911; (in liver cirrhosis), [Labby & others] ★1185
CERCARIA antigens for intradermal testing in schistosomiasis, [Alves] 69—ab
CEREAL PRODUCTS, Gerber's Ready to Serve Barley Cereal, 937
CEREBELLUM, chiropractic injuries, [Pratt-Thomas & Berger] ★600
subdural hydroma, [Grant] 889—ab
vascular lesions, [Skoglund] 201—ab
CEREBRAL Palsy: See Paralysis, cerebral
CEREBROSIDES, staining kerasin in Gaucher's disease, 496
CEREBROSPINAL FLUID, changes from penicillin treatment of syphilis, [Sternberg & Leifer] ★3; [Rose & Solomon] ★7; [Platou & others] ★10
false positive serologic reactions for syphilis, 578
interaction, and Rh agglutinins, [Jakobowicz] 805—ab
protein in subclinical poliomyelitis, [Andelman] 65—ab
CEREBROSPINAL SYPHILIS: See Neurosyphilis
CEREBRUM: See Brain
CERTIFICATION of Specialists: See Specialties
CERVIX uteri: See Uterus
CESAREAN SECTION, anesthesia in, 881
early rising and morbidity in, [Headings] 129—ab
repair of ventral hernia and, 507
CEVITAMIC Acid: See Acid, ascorbic
CHADWICK Lecture: See Lectures
CHAIN, E. B., Nobel Prize winner in Italy, 1030
CHANCRE, time of positive serologic test, 1174
CHANCROID of uterine cervix, [Guerriero & others] ★834
CHARCOAL, value of gastric lavage in treatment of acute poisoning, 545—E
CHEEK, recurrent buccal vesicles from denture, 656
CHEMICAL Burns: See Burns
CHEMISTRY: See Biochemistry
CHEMOTHERAPY: See also Sulfonamide Compounds
background, symposium in *British Medical Bulletin*, 478—E
of wounds, [Lyons] ★215
CHEST: See Thorax
CHICAGO, Institute of Medicine of, Dr. Irons' presidential address, 111—E
Institute for Psychoanalysis, research at, 1023
Public Health Institute closes its doors, 334
CHICKENPOX convalescents, globulins from, to treat herpes zoster, 55
complicating pregnancy, defects in child, [Swan] 1316—ab
diagnosis, simulating rickettsial pox, [Greenberg & others] ★901
CHIEVITZ, OLE, death, 421
CHILDBIRTH: See Labor
CHILDREN: See also Families; Infants; Maternity; Pediatrics; under names of specific diseases
Adolescent: See Adolescence
Child Health Day: May 1st, 1219—OS
clinics for in trailer camps, Calif., 706
development center, N. Y. C., 637
diagnostic services for, extend, N. Y. C., 1293
health service, American Academy of Pediatrics study, (Reference Committee report) 40
Hospitals for: See Hospitals, children's
nurseries (day) for, report on, Sweden, 1300
psychiatric clinics for, 878
school, hospital classroom for, 1291
school, pediculus capitis in, DDT for, [Kaiser] 136—ab; [Cowan] 1305—ab
school, physical examination, 1292
school, ringworm of scalp; present epidemic, [Steves & Lynch] ★306
spacing between, prolonged interval between pregnancies, 578
young, allow to set own pace, [Aldrich] 1314—ab
CHILDS Foundation: See Foundations
CHINA, American Bureau for Medical Aid to China, 709
CHINESE GOLDEN MIRROR OF MEDICINE, in Army Medical Library, 1018
Peiping Union Medical College, Rockefeller Foundation terminates grants to, 564
CHINA (dishes): See Cooking and Eating Utensils
CHINIOFON enerels, N.N.R., (Premo) 543
treatment of amebiasis, 1042
CHIROPRACTORS: See also Medicolegal Abstracts at end of letter M
cerebellar and spinal injuries after manipulation by, [Pratt-Thomas & Berger] ★600
held in fraud, Calif., 875

CHLORIDES: See Choline; Gold; Methyl chloride; Platinum; Sodium chloride; Zephiran chloride
CHLOROBUTANOL, bismuth subsalicylate in oil with, N.N.R., (Abbott) 937
di-CHLORO-DIPHENYL-TRICHLOROETHANE: See DDT
β-CHLOROETHYL AMINES: See Nitrogen Mustard
di-CHLOROETHYL SULFIDE, exposure to mustard gas, 517—ab
possible late mustard gas keratitis, 145
CHLOROFORM, liver injury from, methionine for, (Council report), 107
CHLOROMA, etiology, nature of green pigment, [Humble] 729—ab
CHLOROPHYLL: treatment of wound healing and suppurative disease, [Bowers] 1246—ab
CHOKES, at high altitude, [Burkhardt & others] *373
CHOLAGOGUES: See Bile secretion
CHOLECYSTECTOMY: See Gallbladder excision
CHOLECYSTITIS: See Gallbladder inflammation
CHOLECYSTOGRAPHY: See Gallbladder, roentgen study
CHOLEDOCHOLITHIASIS: See Bile Ducts calculi
CHOLELITHIASIS: See Gallbladder calculi
CHOLERA, Asiatic, streptomycin for, [Reimann] 131—ab
in India, 258
CHOLESTEATOMA: See Epidermoid
CHOLESTEROL-Cephalin Test: See Cephalin
content of human aorta, [Faber] 652—ab
deposition and atheromatosis, [Faber] 70—ab
in Blood: See Blood
CHOLINE: See also Acetylcholine; Mecholyl bromide
chloride, desirable effect on liver in protein deficiency, [Mateer & others] *915
treatment of hepatomegaly and portal obstruction in diabetic child, 279
CHORIOEPITHELIOMA: See Chorionic Carcinoma
CHORIOGONIN, N.N.R., (Lakeside] 1281
CHORIOMENINGITIS, benign lymphocytic meningitis and glandular fever, [Tidy] 728—ab
CHORIONIC CARCINOMA, gift to establish registry from Dr. A. W. Holman, 192
CHORIONIC GONADOTROPINS: See Gonadotropins
CHOROIDITIS, toxoplasmic, neutralizing antibody test for, [Johnson] 647—ab
CHROMAFFIN Cell Tumor: See Pheochromocytoma
CHROMATES, dermatoses in aircraft workers from, [Ellis] 1244—ab
CHRYSOTHERAPY: See Gold
CHYLOTHORAX, traumatic, from battle injury, [Berry] *319
CICATRIX obliteration of esophagus, esophagectomy for, [Sweet], 205—ab
treatment of tender scars, 1174
CIGARETS: See Tobacco
CILIARY BODY spasm as psychosomatic disorder, [Harrington] *670
CINCHOPHEN, acute yellow atrophy of liver, 1156—E
CINEMA: See Moving Pictures
CIRCULATION: See Blood circulation
CIRCULATORY SYSTEM: See Cardiovascular System
CIRCUMCISION of newborn (reply) [Rosenthal] 436
venereal disease incidence in Canadian army affected by, [Wilson] 1243—ab
CIRRHOSIS: See Liver
CITATIONS, Military: See World War II, Heroes
CITRA Neala, 883—Bl
CITRIN: See Vitamins P
CITRUS Fruit: See Fruit; Lemon juice
CLAMS, Alaskan, survey, 708
CLASP Vitamin, Mineral and Herb Formula, 568—Bl
CLAVICLE, resection, [Shumacker] 1314—ab
unduly prominent, in adult renal osteodystrophy, [Norman & others] *771
CLEANSING: See Detergents; Soap
CLEVELAND Health Museum, 1024
CLIMACTERIC: See Menopause
CLIMATE: See Tropics; Weather
CLINICAL Laboratory Technicians: See Technologists, medical
Pathology: See Pathology
Research: See Research
Status: See Physical Examination
CLINICS: See also Amputation; Anaphylaxis and Allergy; Cancer; Epilepsy; Industrial Diseases; Industrial Health; Mental Hygiene; Poliomyelitis; Psychiatry
for children in trailer camps, Calif., 706
Group: See Medicine, group practice
Mental (new), Washington, D. C., 1015
CLOTHING, dress reform, gallstones and tight lacing, [Fishbein] *315
fiber glass, 900
CLOTTING: See Blood coagulation
Intravenous: See Phlebothrombosis; Thrombophlebitis
CLOVER, Preparation from Spoiled Sweet Clover: See Dicumarol
COAGULATION: See Blood
COAL Miners: See Miners
COCAINE, alcoholic beverages doped with, 1253
COCCIDIOMYCOSIS, brain abscess, [Rhoden] 723—ab
diagnosis, clinical and x-ray [Sweigert] 886—ab
varieties, [Smith] 720—ab
COCCYGODYNIA, proctalgias and perianal dyscrasias, [Granet] 127—ab
COFFEE: See also Caffeine
not contraindicated in coronary disease and Buerger's disease, 73
COITUS: See also Contraception; Impotence; Impregnation; Libido; Reproduction; Sperma.ozoa
angulation of penis due to short frenum, 812
COLD: See also Ice
Anesthesia: See Anesthesia, refrigeration
hibernating glands of Merkle: primitive fat organs, 1283—E
hibernation and pituitary hypertrophy, 656
therapeutic use of, in leg injury, [Pernworth] 1308—ab
therapeutic use of (motion picture review), 802
tissue reactions to, [Friedman] 200—ab
COLDS: See also Cough; Hay Fever; Throat; Tonsils, infected
constitutional factor in, 777—E
diphtheritic coryza, [Robin] 429—ab
treatment, difficult of finding cure, 419
treatment, pyogen, spray promoted as "cure" (Joint Council report) 694
treatment, steam inhalations, 1174
COLE, FRANK L., personal, 329
COLESTIN Natural Mineral Water, 568—Bl
COLITIS, amebic, [Ellenberg] 424—ab; 881
amebic disease of cecum, [Wilbur] 1171—ab
amebic, in American troops in India, [Klatskin] 500—ab
amebic, intestinal tumors of dysenteric origin, [Silverman & Leslie] *994
toxic sulfonamide, [Gauss] 719—ab
ulcerative (acute fulminating) with peritonitis, [Chisholm] 134—ab
ulcerative (chronic), appendicostomy in, [Yeomans] 272—ab
ulcerative (chronic), proctologic interpretation and treatment, [Kleckner] *998
ulcerative, late results, [Cave] 132—ab
ulcerative, pleuropneumonia-like organisms relation to, [Wallerstein] 137—ab
ulcerative, succinylsulfathiazole for, [Collins] 1171—ab
ulcerative, thiouracil for, [Martin] 1037—ab
COLLAPSE: See Shock
Pulmonary: See Lungs, collapse; Pneumothorax
Therapy: See Tuberculosis of Lung, artificial pneumothorax
COLLEGE: See also University
Education: See Education, Medical, premedical
Medical: See Schools, Medical
of Medical Evangelists graduate school organized, Calif., 115
of Physicians, Surgeons, etc.: See American College; Royal College; list of Societies at end of letter S
Students: See Students
COLLINS, WILLIAM J., death, 492
COLON: See also Cecum; Colitis; Colostomy
cancer, [Ochsner] 351—ab
congenital megacolon (Hirschsprung's disease), 1043
toxicity of mecholyl bromide, 655
tumors, adenomas; relation to cancer, [Helwig] 1313—ab
tumors, Italian societies discuss, 495
volvulus of ascending portion, [Ericksen & Greenfield] *616
COLOSTOMY for intestinovesical fistula, [Barnes & Hill] *456
COLUMBIA Broadcasting System, "A Long Life and a Merry One," review, 1161
University, research at, 1024
COMBAT: See World War II
COMMENDATION for War Service: See World War II, Heroes
COMMISSION: See also list of Societies and Other Organizations at end of letter S
on Acute Respiratory Diseases, exudative tonsillitis and pharyngitis, *588
COMMISSIONS: See World War II, medical officers
COMMITTEE: See also National Committee; list of Societies and Other Organizations at end of letter S
of A. M. A.: See American Medical Association
on Health Council as agency to promote rural health, [Jones] 864—ab
on Hospital Facilities and Health Centers for Rural Areas, report, [Stewart] 866—ab
on Medical Care for Lower Income Groups, report, [Cooper] 865—ab
on Medical Research, OSRD, accumulated records of, 1295
on Methods of Bringing and Holding Physicians and Dentists in Rural Areas, [Mulholland] 861—ab
on Nursing Needs of Rural Communities, report, [Sewell] 863—ab
COMMITTEE—Continued
on Postwar Medical Service: See American Medical Association Joint Committee for Coordination of Medical Activities
on Voluntary Medical Prepayment Plans, report, [Doughty] 862—ab
COMMONWEALTH Fund: See Foundations
COMMUNICABLE DISEASE: See Infectious Disease
COMMUNITY, medical school responsibilities to, [Greene] *1053
COMPENSATION: See Income; Wages
of Physicians: See Fees
COMPLEMENT-fixation tests for Q fever with paired serums [Irons & others] *819
CONCEPTION: See Impregnation; Pregnancy; Sterility
Control of: See Contraception
CONCUSSION: See Brain; Deafness
CONFERENCE: See National Conference
Annual: See American Medical Association, Annual Conference
Regional, under auspices of A. M. A. Council on Medical Service: American Medical Association Council on Medical Service
CONGO RED test (doubtful) in amyloidosis, [Selikoff] 804—ab
CONGRESS: See also Medical Days; International Congress; National Congress; list of societies at end of letter S
Annual Congress: See American Medical Association
French Congress of Medicine, Oct. 1947, 1234
National Turkish Medical Congress (9th), 1236
of French Society of Otorhinolaryngology, 420
of Psychoanalysts, Italy, 881
of School and University Hygiene, 52; 118
U. S.: See United States
U. S., Medical Bills in (weekly summary): See Laws and Legislation
CONJUNCTIVITIS: See also Keratoconjunctivitis
diagnosis, clinical signs [Thygeson] *437
diagnosis of blepharoconjunctivitis, 900
Granular: See Trachoma
infectious acute, in newborn, A. M. A. Committee introduced silver nitrate to prevent, 1908, [Fishbein] *689
Parinaud's, possible, 357
virus, human globulin for, 508
CONNECTICUT State Medical Society, newspaper advertising, [various authors] 628—ab
CONNOR, LEARTUS, prediction regarding A. M. A. sections; biographical sketch, [Fishbein] *471; *685
CONSANGUINITY: See Marriage
CONSTITUTION: See American Medical Association; World Health Organization
CONSTITUTION (physique): See also Psychosomatic Medicine
aspects of obesity, [Freyhan] 1032—C; (reply) [Fred] 1032—C; [Johnson] 1238—C
factor in common cold, 777—E
CONSULTANTS: See also Army, U. S., Medical Library
medical division, new head; Col. Dooling, 329
CONTACT Dermatitis: See Dermatitis venenata
Lenses: See Glasses
CONTAGION: See Infection
CONTAGIOUS DISEASE: See Infectious Disease
CONTEST: See Prizes
CONTRA Diaphragm, 773
CONTRACEPTION, Contra Diaphragm, 773
Koromex Cream and Applicator, N.N.R., (Holland-Rantos), 321
Lasker award of Planned Parenthood Federation of America, 337
Ramses Vaginal Jelly; Applicator, N.N.R., (Schmid) 1281
right of physician to give advice by mail on, in 1922 [Fishbein] *927
vaginal diaphragm and catheter to control urinary incontinence, [Castallo] *244
vasectomy and ligation of oviducts, 1254
CONTRACT: See Medicolegal Abstracts at end of letter M
Practice: See Medicine, group practice
CONTRACTION: See Cramps; Spasm
CONVALESCENCE: See also Rehabilitation
Care of Patients with Injury to Spinal Cord (motion picture review), 1033
children, Herrick House for children, Ill., 636
early puerperal rising, [King] 129—ab
early rising and morbidity in cesarean section, [Headings] 129—ab
hospitals for rest and, *1066; *1072
CONVALESCENT SERUM: See Chickenpox; Scarlet Fever
CONVULSIONS: See also Eclampsia; Epilepsy
seizures after barbiturate withdrawal, [Osgood] *104
Therapeutic: See Electric shock; Insulin shock
COOKING AND EATING UTENSILS: See also Restaurants
bactericidal detergent for, [Gulteras] 803—ab

COOPERATION, Anglo-French medical, West Africa, 195
COOPERATIVE Medical Advertising Bureau, [Weld] 553—ab; [various authors] 629—ab; (birth of, in 1912) [Fishbein] *767
COPPER salts for chronic rheumatism, [Forestier] 1317—ab
CORAMINE: See Nikethamide
CORLEY'S nostrums, 422—BI
CORNEA, blue halos in atabrine workers, [Mann] 1315—ab
burns (chemical), [McLaughlin] 719—ab
cloudy, goniotomy for congenital glaucoma, [Barkan] *526
eye bank, Stanford establishes, 875
Inflammation: See Keratitis; Keratoconjunctivitis
tattooing; use of platinum, gold chloride, epinephrine (reply) [Knapp] 358
ulcer, sulfhydryl for, [Cruthirds] 131—ab
CORONARY Arteries: See Arteries
Thrombosis: See Thrombosis, coronary
CORONERS, Oakland County deputizes, Mich., 334
system, 1891, [Fishbein] *386
CORPSE: See Autopsies; Embalming
CORPUS CALLOSUM, lipoma, [Amyot] 502—ab
CORPUS LUTEUM Hormone: See Progesterone
CORSETS, tight lacing and gallstones, [Fishbein] *315
COSMETICS: See also Soap
beauty culture, role of medical profession, Denmark, 123
dermatitis in beauty parlor operator, 899
COST of clinical research, A. M. A. Therapeutics Trials Committee report, *30
COSTEN'S Syndrome and head pain, [Bell] 208—ab
COTTON, oxidized, hemostatic dressing in anorectal surgery, [Rosser] 893—ab
suture material, [Derbyshire] 1313—ab
sutures vs. chromic catgut, [Stevens] 891—ab
COUGH: See also Colds; Hemoptysis; Whooping Cough
syrup, [Boyd] 716—C
COUMARIN: See Dicumarol
COUNCIL: See under specific names as Medical Research Council; National Research Council
A. M. A.: See American Medical Association
COUNTY Health Dept.: Units: See Health
Society: See Societies, Medical; list of societies at end of letter S
COURSES: See Education Medical
COURT Decision; Trial: See Medical Jurisprudence
COUSINS, first, marriage of, 1320
COWPER'S Glands: See Bulbourethral Glands
COWPOX: See Vaccinia
COWS: See also Cattle
beat feeds for milk production, 775—E
Milk: See Milk
COX, WESLEY C., personal, 329
CRAIG, ALEXANDER R., A. M. A. secretary, 1911, [Fishbein] *765; (death, 1923) *929
CRAMPS: See also Spasm
Menstrual: See Dysmenorrhea
muscular, and pain in extremities in parkinsonism, 280
CRANE Memorial Lecture: See Lectures
Prize: See Prizes
CRANIUM: See also Brain; Head
injuries, use of fluids in, 214
intracranial pneumograms, [Schneider] 650—ab
porencephaly, [Pendergrass] 136—ab
CRASH Injuries: See Aviation
CREAM: See Butter
of Tartar: See Potassium bitartrate
CRETINISM and marriage, 898
growth promoting agents, 898
CRILE, GEORGE, JR., Naval Medical School lecture, 48
CRIMINALS: See also Impostors
first electrocution in 1891, [Fishbein] *386
CRIPPLED: See Handicapped; Physical Defects; Poliomyelitis
CRYMO Anesthesia: See Anesthesia, refrigeration
CRYSOTHERAPY: See Cold, therapeutic use
CUBA, U. S. blocks shipment of drugs to, 788—OS
CULBERTSON, J. C., editor and manager of JOURNAL, 1891, [Fishbein] *384; *387
CULTS: See also Chiropractors; Naturopathy; Osteopaths
medical profession in relation to, [Fishbein] (1870-1874) *100; (A. M. A. condemns, 1875) *195; (menace, 1921) *924; (Judicial Council decision, in 1924) *933
CULTURE Method: See Bacteria; Leishmaniasis, cutaneous
CURARE, in abdominal surgery, [Howard] 204—ab
intocostrin in shock treatments for mental patients, [Cohen] 503—ab
intocostrin to differentiate muscle spasm from organic changes, [Jones] 139—ab
pentothal-oxygen to relax muscles in abdominal surgery, [Davison] 1245—ab
CURARE—Continued
substitute, bebeerine dimethylether methochloride, Brazil, 882
treatment of muscle spasm in acute low back pain, [Schlesinger] 499—ab
treatment of spasms and rigidity, 882
CURLEY Bu-T-Caps Vitamins; Cal-Pans Vitamins, 264—BI
CURRICULUM: See Education, Medical
CUSHING'S Syndrome, adrenal cortex tumor, [Spence] 1311—ab
CUTTER Lecture: See Lectures
CYST: See also Bartholin Glands; Breast; Mediastinum; Pancreas; Stomach
Pilonidal: See Pilonidal Sinus
Sebaceous: See Steatoma
CYSTITIS: See Bladder
CYSTOSCOPY: See Bladder
CYTRAL, vitamin A fragment, 1235
CZECHOSLOVAKIA, American medical mission to, 545—E

D

DDT, danger in hospital kitchens and dining rooms to control flies, 73
death after exposure to, [Hill] 1036—ab
plane to spray, Florida, 489
transportation of mosquitoes in old tires filled with water, [Pratt] 725—ab
treatment of pediculosis, 733
treatment of pediculus capitis in school children, [Kaiser] 130—ab; [Cowan] 1305—ab
DFP treatment of myasthenia gravis, [Comroe] 886—ab; 1252
D. H. E. 45 (dihydroergotamine) in migraine, [Pollock] 502—ab
DPS Formulae; DPS Formula 56, 264—BI
DA COSTA Syndrome: See Asthenia, neurocirculatory
DAIRY PRODUCTS: See Butter; Milk
DANDRUFF: See Alopecia seborrheica
DANISH Medical Association, 123; (Domus Medica) 961
DART, RAYMOND O., new director of U. S. Army Institute of pathology, 252
DAVIS, NATHAN SMITH, first editor of the JOURNAL, [Fishbein] *239; (account of progress in 1885) *310
memorial to [Fishbein] *683; *763; *765; *841
presidential address, 1865, [Fishbein] *24
DAVIS Lecture: See Lectures
DAY Nurseries: See Children
DAYLIGHT saving time advocated by A.M.A., [Fishbein] *848
DEAD BODIES: See Autopsies; Embalming
DEAF-MUTISM, rubella in pregnancy cause of, 1012—E
DEAFNESS: See also Hearing, impaired
concussion, in 100 gunnery instructors, [Stewart] 63—ab
congenital, in child; German measles in mother, [Hopkins] 268—ab; [Clayton-Jones] 1316—ab
diagnosis, course in audiometry, Iowa, 1292
Eighth Nerve: See Otosclerosis
evaluating percentage in medicolegal cases, standard procedure, (Council report) *396
mild perceptive, with tinnitus aurium, 436
traumatic, ear plugs to prevent, 1174
Treatment: See Hearing aids
DEAN'S Committee: See Schools, Medical
DEATH: See also Coroners; Embalming; Murder; Suicide
Accidental: See Accidents, fatal
Cause of: See also Accidents, fatal; under names of specific conditions and substances as Anesthesia
cause of, Analbis Suppositories, 852—E; [Weinstein] 962—C
cause of, posttransfusion death in infant, 811
Examination After: See Autopsies
of Fetus: See Fetus
of Infants: See Infants, mortality
of Physicians: See Physicians, death; list of deaths at end of letter D
Postmortem: See also Autopsies
postmortem direct electrocardiography of restored human heart, [Andreyev] 431—ab
Rate: See Vital Statistics
sudden and unexpected, of young soldiers, 325—E; [Moritz] 721—ab
sudden heart, pathologic anatomy, [Munck] 968—ab
thymic, 644
time of, body temperature as guide in determining, 195
DECELERATOR, impact, [Bierman & others] *522
DECIDUA: See Endometrium
DECIDUOMA malignum: See Chorionic Carcinoma
DECOMPRESSION SICKNESS: See Altitude, high
DEERFLY Fever: See Tularemia
DEFECTS, Physical: See Abnormalities; Disability; Handicapped; Physical Defects
DEFENSE, National: See World War
DEFICIENCY DISEASE: See also Beriberi; Nutrition deficiency; Pellagra; Scurvy; Vitamins deficiency
DEFICIENCY DISEASE—Continued
tongue changes in British troops, [Smith] 68—ab
wound healing in, [Wolfer] 1313—ab
DEFINITION: See Terminology
DEFORMITIES: See Abnormalities; Poliomyelitis
DEGLUTITION: See Plummer-Vinson Syndrome
DEGREE: See Health, public; Technologists
DEHYDRATION, toxicity of mercurial diuretics, [Ben-Asher] 348—ab
treatment, intravenous infusion [Borst] 968—ab
DEHYDROCHOLIC Acid: See Acid
DE LAMAR Lecture: See Lectures
DELIVERY: See Labor
DELOUSING: See Pediculosis, treatment
DEMENTIA PARALYTICA, treatment, penicillin or plus fever, [Rose & Solomon] *6
DEMENTIA PRECOX, schizophrenia in children, [Schuma her] 649—ab
schizophrenia (transitory) in bromide intoxication, [Levin] 130—ab
treatment, insulin plus electroshock in schizophrenia, [Polatin] 726—ab
DEMEROL HYDROCHLORIDE: See Meperidine
DEMOBILIZATION: See World War II, medical officers
DENIT, GUY B., personal, 329
DENTAL: See under Dentistry
Caries: See Teeth
Practice Acts: See Medicolegal Abstracts at end of letter M
DENTISTRY: See also Jaws; Teeth
Committee on bringing and holding dentists in rural areas, [Mulholland] 861—ab
dental benefits under British National Health Insurance Act [Josselyn] 125—C
dental health services under Taft-Smith-Ball-Donnell Bill 870—OS
Eastman Institute provides free care to children, Stockholm, 712
experiment in dental hygiene, Norway, 263
DENTISTS: See Dentistry; Medicolegal Abstracts at end of letter M
DENTURE: See Teeth, artificial
DEODORANT: See Odor
DEPRESSION, Mental: See Melancholia; Mental Depression
DEPROPANEX, effects of cholagogues on coronary occlusion, 146
DEPROTEINATED Extract of Pancreatic Tissue: See Pancreas
DERMATITIS: See also Eczema; Urticaria
arsenical, BAL for, [Sulzberger & Baer] *293
Atopic: See Neurodermatitis
Contact: See Dermatitis venenata
cosmetic, in beauty parlor operator, 899
exfoliativa, after gold therapy, 507: 733
gold, BAL for [Ragan & Boots] *752
Industrial: See Industrial Dermatoses
lichenoid pigmentary, [Wilson] 200—ab
Poison Ivy: See Rhus
quinacrine, [Drake] 134—ab; [Peterkin] 727—ab
ragweed, [Slater] 803—ab
recurrent vesicular, of hands, [Flood] 892—ab
rubber balloon cause of, 1174
venenata, from Japanese rifles, [Hinman] 132—ab
venenata from marine animal contact, [De Oreo] 720—ab
venenata, from penicillin, [Friedlaender] 269—ab
DERMATOLOGY: See also Skin; under names of specific skin diseases
Hispano-Portuguese Congress (1st), 566
5-nitro-2-furaldehyde semicarbazone, [Downing & others] *299; [Morin] 963—C
DERMATOSIS: See Industrial Dermatoses; Skin disease
DESENSITIZATION: See Anaphylaxis and Allergy
DESOXYEPHEDRINE (methedrine) in psychiatric diagnosis, [Simon] 724—ab
DETERGENTS: See also Soap; Zephiran chloride
bactericidal, for cooking and eating utensils, [Guiteras] 803—ab
toxicity if swallowed? 358
DETERIORATION, tropical, 1216—E
DEXTRI-MALTOSE, treatment of peptic ulcer, [Co Tui] 1312—ab
DEXTRO-QUININE, 568—BI
DEXTROSE, glucose vs. anoxia in flying personnel, 776—E
DIABETES INSIPIDUS with postpartum pituitary necrosis, [Spain] 727—ab
DIABETES MELLITUS, Cleveland Diabetes Society organized, 336
committee, W. Va., 415
complications, arteriosclerotic leg, 1320
complications, chronic peptic ulcer, [Wood] 1240—ab
complications, hepatomegaly and portal obstruction in child, 279
complications, pregnancy; hyperplasia of Langerhans islets in fetuses, [Hultquist] 1318—ab
diagnosis (differential) of glycosuria, 278

133
947

DIABETES MELLITUS—Continued
Diet in: See Diabetes Mellitus, treatment
etiology, excessive use of sugar or glucose cause? 734
etiology, prolonged treatment with thyroid, 195
etiology, pseudoglycosuria in patients treated with penicillin, [Boldyreff] 715—C
experimental, in rats, age in relation to, 196
experimental, induced by alloxan, 195; 496
insulin in, globin insulin with zinc, N.N.R., (Squibb) 543
insulin resistance (extreme), [McGavack] 891—ab
New England Association (first meeting) 1025
New Jersey Diabetes Association, 1293
New York Diabetes Association, (aids research) 117; (meeting) 876
pancreatic, hyperthyroidism effect on, 195
research, fellowship established, Pa., 50
treatment diets, simplified method for calculating [Cao & Stare] ★169
DIABETES, RENAL: See Glycosuria
DIAGNOSIS: See also under names of specific diseases
Case Finding: See Tuberculosis
children's, diagnostic services, extend, N. Y. C., 1293
Clinic: See Cancer; Industrial Diseases
problem: syncope, [Brian] 351—ab
significance of breast striae, 358
DIALYSIS, peritoneal, for anuria, [Reid] 503—ab
DIAMIDINES treatment of kala-azar, 420
DIAPHRAGM, abscess (subdiaphragmatic) [Adams] 650—ab
DIAPHRAGMS (vaginal), Contra Diaphragm, Council accepted, 773
plus catheter to control urinary incontinence, [Castallo] ★244
DIARRHEA: See also Dysentery
acute fulminating ulcerative colitis with peritonitis, [Chisholm] 134—ab
epidemic in infants, Mass., 489
epidemic in newborn, Mass., [Rubenstein] 1311—ab
epidemic in newborn nursery secondary to milk-borne epidemic, [Ensign] 271—ab
prophylaxis in newborn, [Weymuller & others] ★82
treatment, bismuth subnitrate causes methemoglobinemia in infant, [Wallace] ★1280
Trichomonas hominis and, 145
DIASONE treatment of leprosy, [Muir] 967—ab
DIATHERMY, home, (Council report), 541
Kirschner electrocoagulation of gasserian ganglion, 577
DIBENZYL-METHYL-AMINE: See *alpha*-Fagarine
DICHLORO-DIPHENYL-TRICHLOROETHANE: See DDT
DICHLOROETHANE (ethylene dichloride) 577
DICHLOROMETHANE (methylene dichloride), toxicity, 145
DICOUMARIN: See Dicumarol
DICTION: See Terminology
DICUMAROL, anticoagulants and coronary thrombosis, 970
treatment, contraindicated for priapism in leukemia, 73
treatment of acute coronary occlusion, 357
treatment of multiple sclerosis, [Putnam] 1306—ab
treatment of venous thrombosis and pulmonary embolism, [Allen & others] ★1268
DIET: See also Dietitians; Food; Nutrition
after cholecystectomy, 213
Calories in: See Calories
canine hysteria and, [Mellanby] 805—ab
Carbohydrates in: See Carbohydrates
cards available for physicians interested in infant and child feeding, W. Va., 116
Deficient: See Nutrition
Diabetic: See Diabetes Mellitus, treatment
Fat in: See Fat
in liver impairment, [Mateer & others] ★915; [Witts] 1315—ab
Infant's: See Infants, feeding
Protein in: See Protein
Reducing: See Obesity, treatment
Salt Free: See Salt
Therapeutic: See Diabetes Mellitus; Heart Insufficiency; Jaundice; Liver cirrhosis
tuberculosis in captive wild birds relation to, [Rateliffe] 888—ab
Vitamins in: See Vitamins
DIETHYL ETHER, treatment; [Wirtschafter & Widmann] ★604
DIETHYLSTILBESTROL, effect on experimental diabetes mellitus, 195
N.N.R., (Harrower; Miller; Premo; Vale) 477
DIETITIANS needed for U. S. Army, 408
in all hospitals, ★1077
DIGITALIS, new extracts, 643
poisoning retrobulbar neuritis and complete heart block, [Wagener] 200—ab
prophylactic digitalization, 508
treatment of acute coronary occlusion, 357
DIHYDROERGOTAMINE (D. H. E. 45) in migraine, [Pollock] 502—ab
DI-ISOPROPYL-FLUOROPHOSPHATE in myasthenia gravis, [Comroe] 886—ab; 1252
DIMELS, 883—BI
2,3 DIMERCAPTOPROPANOL: See BAL
beta **DIMETHYLAMINOETHYL** Benzhydryl Ether Hydrochloride: See Benadryl
DINGELL-Wagner-Murray Bill: See Wagner
DIODE (motion picture review), 802
DIODOQUIN treatment of amebiasis, 1042
DIPHTHERIA, anergy in infants skin to, [Wright] 573—ab
antitoxin (circulating) in, [Ipsen] 1243—ab
antitoxin introduced, 1896, [Fishbein] ★468
carriers, [Reber] 1317—ab
carriers, penicillin treatment, [Karelitz] 1310—ab
complications, late neuronitis, [Sampson] 129—ab
complications, neurologic [Bronson] 500—ab
coryza, [Robin] 429—ab
gravis, electrocardiography in, [Giraud] 353—ab
in Boston, 1228
in recent years, [Mortenson] 504—ab
increase, (N. C.) [Stevick] 204—ab; (sharp, Mass.) 637; (New York) 1164; (N. J.) 1293
Malignant: See Diphtheria gravis
mortality, increase in 1946, Ill., 954
prevention in Sullivan County, Ind., 1228
skin, [Livingood] 892—ab
toxin, antidotal property of filtrates of Penicillin notatum, 33—E
treatment, penicillin, [Karelitz] 1310—ab
DIPLOMA Mills: See Licensure
DIRECTORY: See American Board of Ophthalmology; American Medical Directory; American Medical Association, Directory Department
DIRT: See Dust
Removal of: See Detergents
DISABILITY: See also Handicapped; Industrial Accidents; Physical Defects
exhibit showing conquest of disablement, 566
from accidents, National Safety Council report, 564
in Veterans: See Veterans, disabled
Rehabilitation after: See Rehabilitation
200,000 Americans are potentially unemployable each year through disablement, 788
War: See Rehabilitation; Veterans, disabled; World War II, casualties
DISCHARGE of Medical Officers: See World War II, medical officers
DISEASE: See also Autopsies; Death; Diagnosis; Health; Pathology; Patients; under names of specific diseases
allergy in production of lesions in, 776—E
Carriers: See Diphtheria; Streptococcus; Typhoid
Chronic: See Disease, incurable; Disease, long term
Contagious: See Infectious Disease
Convalescence from: See Convalescence
Deficiency: See Deficiency
Diagnosis: See Diagnosis
Disabling: See Disability
Early Rising: See Convalescence
Epidemiology: See Epidemiology
genetic, prevention, 547—E
Hazard: See Industrial Diseases
incurable, remedies sought through atomic energy 631—OS
Industrial: See Industrial Diseases
long term illness in modern society, [Bluestone] ★1051
Mental: See Mental Disorders
new: rickettsial pox, [Huebner] 272—ab; [Greenberg & others] ★901
Nomenclature: See Terminology
Occupational: See Industrial Diseases
Physical-Mental Relationship: See Psychosomatic Medicine
Prevention: See Preventive Medicine
Rate: See Vital Statistics
Sickness Insurance: See Insurance, sickness
Spread of: See Epidemiology
Treatment of: See Hospitals; Therapeutics
Tropical: See Tropical Disease
DISHES: See Cooking and Eating Utensils
DISINFECTION: See Bactericides
of Air: See Air disinfection
DISLOCATION: See Jaws; Spine
DISTINGUISHED Service Medal: See World War II, Heroes
DITHIOPROPANOL: See Bal
DIURESIS, mercurial, tetany after, [Marshall] ★1007
mercurial, toxicity, [Ben-Asher] 348—ab
DIVERTICULOSIS: See Intestines
DIVORCE: See Medicolegal Abstracts at end of letter M
DIZZINESS: See Vertigo
DOCK (George) Lecture: See Lectures
DOCK workers, pneumonoconiosis in, [Dunner] 428—ab
DOCTORS: See Physicians
"Doctors—Then and Now": See American Medical Association radio program
Trade names beginning with "Dr.": See under surname concerned
DOCVETS, Physicians Veterans of World War II, 184—OS; 1159—OS
DODSON, JOHN M., editor-in-chief of *Hygeia*, 1923, [Fishbein] ★931
DOGS: See also Rabies
atherosclerosis in, [Steiner] 133—ab
diet and canine hysteria, [Mellanby] 805—ab
DOGS—Continued
Seeing Eye Dog, hoax, 191
vaccination required, N. Y. C., 116
DOLANTIN: See Demerol
DONATIONS: See Fellowships; Foundations; Hospitals; Library; Prizes; Research grants; Scholarships
DONNELL-Taft-Smith Ball Bill: See Taft
DONOR: See Blood Transfusion
DONOVAN Bodies: See Granuloma inguinale
DOOLING, HENRY C., new head of medical consultants division, 329
DORYL treatment of myasthenia gravis, 1252
DOUCHE, vaginal, 508
DOYNE Medal: See Prizes
DRAINAGE: See Biliary Tract; Bladder
DRESS: See Clothing
DRESSINGS: See also Adhesive; Cast; Medical Supplies
cellophane wrapping of patent ductus arteriosus, [Poppe] 204—ab
fixing nasal tube with gauze bandage, [Schroff] 345—C
gelatin sponge as hemostatic dressing in anorectal surgery, [Rosser] 893—ab
surgical, indictment charging restraint of trade in, 52
DRINKING: See Alcoholism; Water
Utensils: See Cooking and Eating Utensils
DRIVING: See Automobiles
DROPSY: See Ascites; Edema
DRUGGISTS: See Pharmacists
DRUGLESS Healers: See Cults
DRUGS: See also Medical Supplies; Pharmacopeia; and under names of specific drugs
Addiction: See Meperidine; Morphine; Narcotics
advertising products to the public, Council discusses, 850
alcoholic beverage doped with, 1253
Anesthetic: See Anesthesia
antagonism of barbiturates and amphetamine sulfate, 280
antipyretic, effects on measles eruption, 508
commentators fear production of moving picture glamorizing use of, 46—OS
decompression sickness prevented with [Williams] 1308—ab
Eruptions: See Dermatitis: Eruptions
manufacturers should market in bulk form as accepted dosage form, Council discusses, 850
N. N. R.: See under names of specific drugs
National Formulary published, 52
Patent Medicines: See Nostrums
Prescriptions: See Prescriptions
Priorities and Allocations: See Priorities and Allocations
Proprietary: See Proprietaries
shipment to Cuba, U. S. blocks, 788—OS
surplus, sale, 951; 1162
Technical Intelligence Division investigation, (Council discusses) 851
Therapeutic Use: See Chemotherapy; Self-Medication; Therapeutics; under names of specific diseases
Traffic: See Narcotics
U. S. Food and Drug Administration; Legislation: See Food.
DRUNKENNESS: See Alcoholism
DUCREY'S Bacillus: See Chancroid
DUCTLESS GLANDS: See Endocrine Glands
DUCTUS ARTERIOSUS, patent, cellophane wrapping and ligation of, [Poppe] 204—ab
patent in 3 sisters, [Kjaergaard] 504—ab
patent, surgical treatment, [Bradshaw] 348—ab
DUCTUS BOTALLI: See Ductus arteriosus
DUKE University, effect of immunization on epidemic influenza, [Broadbent] 204—ab
DUNGLISON, R. J., A. M. A. treasurer, 1894, [Fishbein] ★391
DUODENAL TUBE, fixing nasal tube with gauze bandage ties, [Schroff] 345—C
DUODENUM, cancer, (primary) [Castex] 806—ab
roentgen study, ulcer perforates during, [Schilling] 373—ab
Ulcer: See Peptic Ulcer
DUST, Disease from inhaling: See Pneumonoconiosis
from paper, effect of, 435
Removal: See Detergents
study of air pollution in Chicago, 334
DUSTING POWDER, tetanus from infected talc, fatal to 3 infants, Australia, 1031
for rubber gloves, 1218—E
DUTCH: See Netherlands
DWARFISM, growth promoting agents, 898
Renal: See Osteodystrophy
DYES: See Congo Red; Green; Methylthionine Chloride; Pigment
DYNAMITE encephalosis, [Gerle] 142—ab
DYSENTERY: See also Diarrhea
Amebic: See Colitis, amebic
intestinal tumors due to, [Silverman & Leslie] ★994
DYSGERMINOMA of ovary, [Custer] 66—ab
DYSMENORRHEA, treatment, benadryl, [Tyson] 137—ab
treatment, surgical, [Duncan] 803—ab
DYSPNEA: See Asthma
DYSTONIA musculorum deformans, 278
DYSTROPHY: See also Osteodystrophy; Osteoporosis, posttraumatic
Muscular: See also Myasthenia gravis
muscular progressive, inheritance, 212

DEATHS

A

Abercrombie, Joseph Albert, 1232
Abrahamson, Philip, 640
Adams, Edward C. Leverett, 338
Allen, Harry W., 1026
Allen, Irving Cyrus, 640
Allen, M. H., 1026
Anderson, Arthur, 640
Anderson, John Jr., 1026
Anderson, John Steel, 958
Anderson, Reuben Bennett, Jr., 193
Anderson, Ross Epting, 1026
Andrew, John, 1166
Andrews, Harold Edwin, 1232
Archer, James Cox, 1296
Armstrong, Jeremiah Frank, 53
Arnold, Charlotte E. Cooke, 1026
Arnold, Enga Mitchell, 259
Arnson, Julius Ord, 119
Ashworth, John, 119
Austin, Howell Hobbs, 1166
Averill, Edna Blanche, 1232
Axelson, John M., 53

B

Baerens, Oscar Frank, 1026
Bailey, James William, 53
Bailiff, Jesse Oscar, 259
Baker, William Asa, 1026
Baker, William Thomas, 1232
Bales, Blenn Rife, 53
Ball, Thomas Joseph, 417
Ballard, Sylvester L., 1026
Bancroft, Henry Valentine, 1026
Barbash, Samuel, 259
Barber, Leon James, 493
Barclay, Alexander James, 193
Barefoot, Mordecai Lee, 338
Barker, Williston Wright, 417
Barker-Ellsworth, Alice, 1296
Barnett, Arthur Franklin, 565
Barnett, Cecil Ernest, 1232
Barry, Albert Francis, 640
Barry, Chester Leroy, 1026
Bartley, Charles P., 338
Bass, Frank Earl, 795
Bauer, John A., 259
Beachler, George Frederick, 193
Beall, Khleber Heberden, 958
Beatty, George Evans, 493
Becton, Edwin P., 259
Beckel, Frederick, 119
Beery, George W., 640
Behrens, Charles Bernhardt, 193
Belden, Louis DeKeyser, 338
Belding, Clifton LeRoy, 259
Beling, Christopher Charles, 417
Benson, Arthur Wight, 53
Bentley, Frederick James, 1232
Berger, William John, 958
Bernfield, Martin Aaron, 1296
Berns, Peter C., 1296
Bertram, Bernard John, 259
Besser, Edward Francis, 565
Best, Marshall Merrill, 1296
Bisson, Walter Clinton, 259
Blair, Mott Parks, 417
Boenke, Rudolph, 193
Bogar, Joseph E., 1026
Bogomolets, Alexander A., 123
Boland-Wegmann, Sarah Jane, 640
Bonnell, Harry Granville, 119
Bonoff, Zelly Adam, 1296
Bookout, Alton Coleman, 711
Borders, Dennis J., 417
Bosselmann, Clarence Conrad, 338
Bourque, Norbert Odeon, 338
Bradburn, Hubert Benjamin, 194
Brand, Eli Thomas, 493
Brav, Max, 879
Breckenridge, Arnold, 796
Breuer, Charles Hugh, 640
Brewster, Roger Bernard, 795
Bridge, M. L., 259
Brigham, Frank T., 493
Briskman, Alfred Lee, 417
Bronson, Albert F., 339
Brooks, Charles Newton, 417
Brown, Andrew Jackson, 1296
Brown, Henry Harold, 1026
Brown, Thomas, 1296
Brown, Mark Atkins, 1026
Brown, Michael, 795
Brown, Tony Christensen, 958
Brownlee, Hugh Ria, 493
Buckhold, Wilbert William, 340
Burdenko, Nikolai Nilovich, 52, 714
Burdett, Joseph R., 1296
Burdine, Ira Price Jr., 1296
Burgwin, Charles Wesley, 958
Burns, Sherman Moran, 493
Burrows, Lilburn Ira, 1296
Butt, William Edward, 339
Byerly, Andrew Baxter, 565
Byers, George Allan, 1166
Byrne, Cyril Joseph, 259

C

Caldicott, Francis Stephen, 1232
Caldwell, George Thomas, 1166
Camp, Foster Kendrick, 493
Camp, George Hull, 1296
Campbell, Benjamin Franklin, 1232
Campbell, Edward A., 53
Card, William Ridgeway, 1027
Carl, Allen Vincent, 259
Carpenter, William Howard, 879
Carper, Oscar Winfred, 193
Carr, John Dennis, 339
Carr, John George, 193
Carson, Ernest Marion, 493
Castaneda, Gonzalo, 492
Castleman, Frank Riley, 193
Caudill, Fred Welden, 795
Chamberlain, George Lafayette, 1027
Champlin, Henry D., 259
Chapman, George Andrew, 493
Chase, Daniel Robert, 1027
Chase, Lynn Brownell, 119
Cheever, Clarence Alonzo, 795
Chenoweth, Perthas Calvert, 417
Cherrington, John Summerfield, 119
Chievitz, Ole, 421
Chilton, William Chapman Jr., 193
Chipman, Ernest Dwight, 493
Chipman, Herbert A., 565
Christie, George Ralph, 1232
Church, Nathan W., 193
Claassen, Harry Louis, 795
Clark, Bruce, 958
Clark, Edward W., 1166
Clarke, Edward Wight, 339
Clarke, Henry Little, 339
Clarke, William Oscar, 879
Clayton, Archie Leonard, 493
Clime-Weber, Edith M., 1027
Cline, Bernard McHugh, 1296
Clouse, William Harrison, 1027
Coats, David Z., 640
Cody, Henry L., 493
Coffler, Mayer S., 119
Cohenour, Vincent Jacob, 339
Cohn, Allan Loeb, 1296
Collins, William J., 492
Collom, Clyde C., 958
Combs, Waller Glenmore, 493
Conlee, Charles C., 640
Connell, James R., 193
Cook, Charles G., 879
Cook, John Oliver, 417
Cooke, A. Bennett, 493
Corns, William, 1296
Cornue, Perry Wessel, 640
Corrigan, Joseph Jr., 710
Cosby, Arthur Garfield, 417
Costanzo, Ralph Edward, 796
Coughlin, Thomas Francis Jr., 1232
Cox, Robert Houk, 493
Coyle, Anna Elizabeth Mulheron, 1296
Cragg, Harry Clifford, 1166
Craig, James W., 958
Crane, Homer Winfield, 493
Cravens, James A., 339
Crawford, George Minton, 640
Crawford, Porter James, 640
Cremeens, George L., 493
Cressy, William Hartwell, 1296
Crikelair, Frank Leander, 1233
Crittenden, Alden Larue, 1296
Croman, Joseph M. Sr., 493
Crosby, Leander Marshall, 53
Crossette, George Dart, 417
Crowe, Matthias James, 1233
Crudup, Charles Percy, 640
Culbert, William Ledlie, 259
Curry, William Jasper, 795

D

Dalphin, Percival F., 119
Darnell, Matthew Cotton, 53
Dauber, Deborah Vivian Rubenstein, 493
Davie, Mercer Stillwell, 1166
Davis, Isaac, 795
Davis, John B., 339
Davis, John Staige, 338
Davison, Charles Marshall, 338
Day, Samuel Walton, 640
Day, William Elton, 1233
Dean, Ray E., 259
Deane, Frank Herbert, 339
Dearborn, Ray Russell, 640
Deardorff, Benjamin Miles, 1027
De Grand, Alexander J., 417
Dempsey, Domnick Patrick, 493
Dennett, Alonzo Austin, 53
Dewey, Grace, 259
Deyerle, James Henry, 640
Dickson, David A., 119
Diemer, Louis Merriew, 958
Dilding, Arthur Royal, 640
Dilley, Fred Counselman, 259
Dittman, George Claude, 795
Doern, William G., 339
Donald, Thomas Claude, 493
Donlon, Stephen Edward, 795
Donohoo, Joseph, 339
Donovan, William, 1296
Douglass, Henry Beaman, 493
Douglass, James E., 710
Downer, Earl Bishop, 795
Downey, Martin, 259
Downing, Robert Elisha, 193
Dresbach, Melvin, 193
Duclos, Joseph Achille, 259
Dulaney, Henry Parrott, 1026
Dunn, James Washington, 1027
Durrance, Frederick York, 193
Dwight, Kirby, 494
Dye, Frank Ganes, 710

E

Earling, Howard, 796
Ederer, John Joseph, 494
Edwards, George Boardman, 494
Elscheid, Rudolph John, 53
Elseline, Daniel Alverson, 710
Elder, David G., 339
Elliott, Hiram Clifford, 640
Embry, George Estle, 795
Enfield, Charles Darwin, 193
England, John D., 417
Erhard, Elmer Sylvester, 494
Ervay, Fred Leslie, 1296
Erwin, Herbert Jones, 879
Eshleman, Edwin Franklin, 710
Etienne, Arthur O., 640

F

Farrar, George William, 339
Farrar, John O'Fallon, 1296
Favill, John, 493
Feldman, Gordon Glenn, 1166
Fenlon, Leslie Knapp, 53
Fenno, Frederic Reid, 796
Finley, Thomas R., 640
Fischer, Oscar Edward, 640
Fish, Clyde Mulhallon, 417
Fisher, Charles Edward, 1233
Fisher, Frank Crist, 1296
Fisher, Ralph Stephen, 1027
Fletcher, Emerson Armor, 494
Flotte, Camille Joseph, 1027
Flynn, William Vincent, 259
Foerter, Adolph J., 640
Foltz, Esgar Bowen, 119
Ford, Richard Bland, 879
Fortune, Hannibal Claude, 795
Foshager, Henry Theodore, 193
Fossum, Cornelius A., 1296
Foster, Frank W., 339
Foster, James LeRoy, 1027
Fournier, Marc A., 1027
Fowler, James Thomas, 1027
Fraley, James Jerdan, 417
Freeman, George McClellan, 640
Freiman, George, 795
French, DeKoven Alexander, 710
Frick, Lewis, 53
Frost, Harry Theodore, 53

G

Gaharan, James Alexander, 259
Galbreath, William Robert, 796
Gale, George Thomas, 53
Gallagher, Ambrose William, 640
Gallagher, James Griffin, 640
Galvin, Thomas Edward, 1027
Gardner, Frank Williams, 640
Garrett, Broox Cleveland, 339
Garton, Will Melville, 640
Garver, Clifton, 338
Garvin, Justin Allis, 640
Gauss, Julius Henry Philip, 494
Gebhardt, Albert Alexander, 339
Geiger, Charles George, 640
Gellen, Johanna, 1296
Gerry, Carroll Hunter, 1027
Gewanter, Robert, 641
Gholston, William Dabney, 1233
Gibby, Isabelle Parker, 879
Gideon, John Relda, 1296
Gigger, Augustus George, 641
Gillespie, George Yancey Sr., 641
Glovinco, Calogero, 1027
Glaser, Mark Albert, 339
Glass, Edwin Blanchard, 641
Godfrey, Joseph Witter, 417
Goldberg, Milton, 958
Golden, Matthew Gerard, 494
Goldstein, William Hyman, 53
Goldthwaite, Harmon Reasoner, 641
Goode, George Henry, 1233
Gordon, Donald Cameron, 1026
Goss, George W., 339
Grady, Oliver George, 795
Grant, Justin Frank, 1027
Grant, Stowell Burrough, 1296
Greeley, Philip Hartson, 494
Greene, Christiana Marion, 1166
Gregg, Grant W., 119
Gregory, George Augustus, 641
Grizzard, James Alexander, 1027
Guyton, Willard Arthur Jr., 641

H

Hadley, John L., 339
Haines, Edgar James, 494
Hains, John William, 958
Hale, William, 338
Haley, Mark Joseph, 417
Hall, Bishop Adams, 641
Hall, Joseph Underwood, 417
Hall, Mercer Freeman, 1027
Hall, Ralph William, 641
Haller, John Paulett, 193
Hamilton, Charles William, 1296
Hamilton, Howard Eugene, 1027
Hamilton, Richard Theodore, 958
Hammond, H. Herbert, 53
Hanley, Harold Edward, 194
Hanna, John Kennedy, 339
Hansen, Lester Bryan, 1166
Hare, Charles Henry, 1232
Harin, Nicholas N., 641
Harrington, Charles D., 339
Harris, Caleb Wooster, 339
Harris, Charles Hickman, 641
Harris, Morris Louis, 259
Harris, William John, 641
Hartley, Millard L., 1166
Hartman, James Henry, 641
Hassenmiller, Martin, 339
Hawes, Ira H., 339
Hawkins, Vallandingham, 1027
Haynes, Henry M., 119
Hays, George Richard, 641
Hazard, Charles Merrill, 1296
Hazlett, Edgar Marion, 339
Heacker, Herman Everett, 259
Heagerty, William Bowen, 119
Heil, Alva Arling, 958
Helmlich, Daniel, 795
Hemker, William Harrison, 641
Hempelmann, Louis Henry, 710
Hennessey, Edward H. J., 418
Hennessy, Maurice Alphonsus Regis, 795
Henslee, Samuel Clifford, 53
Herrmann, Arthur John, 641
Hertel, Henry George, 641
Hervey, Samuel W., 795
Herzen, Piotr A., 1235
Hickman, John Samuel, 418
Hielscher, Julian Adolph, 641
Hill, Eleanor Jane, 641
Hill, Harold Phillips, 641
Hill, James Henry, 1297
Hill, James Wallace, 1027
Hirshfeld, Samuel, 641
Hittner, Henry M., 418
Hoffmann, George Henry, 1166
Hogle, William Milo, 641
Holder, Eugene Ward, 710
Holladay, Lewis, 641
Holt, William Leland, 119
Hood, Charles Edwin, 1297
Horner-Rodger, Clara Louisa, 1166
Horsford, Frederick Charles, 565
Horton, Joseph Hubert, 259
Howard, Perez Briggs, 1027
Howe, Jesse Burket, 260
Hubbard, Roger Wolcott, 53
Huff, Trent Orin, 1027
Huffman, Alonzo, 641
Hughes, Edgar Hamill, 641
Hughes, John Elmer, 795
Humphrey, James Alton, 260
Hutchinson, Charles Martin, 339
Hutchinson, Robert James, 795
Hutton, Byrt Boone, 193
Hutzelman, Jacob Casper, 879
Hyatt-Smith, Mary Elizabeth, 641

I

Ihrke, Irvin Arthur, 879
Ilderton, John Allan, 494
Ingersoll, John Marvin, 1026
Ingrish, George Albert, 565
Ishkhanian, Nouri Iskandar, 641

J

Jack, John Jones, 1297
Jack, William George, 958
Jackson, Clarence Martin, 795
Jacobi, Stella Elora Chapman, 339
James, Norman Gilchrist, 339
James, Samuel Henry, 1027
James, William Daniel, 1027
Jarmulowsky, Harry, 1297
Jarrell, Kyle McCue, 1027
Jennings, Douglas, 565
Jobson, George Balgerie, 54
Johns, J. H., 1297
Johnson, Arthur Edward, 1166
Johnson, Herbert Lewis, 1233
Jones, Edward Stanton, 565

Deaths—Continued
Jones, Isaac William, 1233
Jones, John Paul, 194
Jones, Leslie W., 418
Jordan, Grace Elizabeth Atkins, 1297

K

Kalinowski, Nicholas, 710
Karch, John McLean, 1297
Kaufman, Julius Robert, 796
Kaufman, Victor Eugene, 795
Kees, Philip Arzt, 338
Kelly, Helen Jeffery, 54
Kelly, John Frederick, 1166
Kemp, Thomas Junior, 1297
Kendall, Anson Herbert, 958
Kendall, Edward James, 1233
Kerrigan, Joseph Henry, 795
Kessler, Herman, 1233
Kilgore, Franklin Taylor, 641
Kitchen, Arthur Samuel, 54
Klingner, Thomas Otis, 795
Knabb, Frank Peter, 1297
Kneller, John Arthur, 194
Knob, William Isaacson, 1297
Koon, Thomas W., 641
Koones, Charles Kneller, 1027
Koppel, Joseph Abraham, 418
Kronrad, Lorenz, 1297
Kuegle, Frederick Henry, 260

L

LaBorde, Jean Baptiste, 1297
Lally, Bernard Vincent, 1297
Lambert, Junius L., 958
Lambert, Sylvester Maxwell, 795
Lambright, Simeon, 339
Lancaster, Herschel W., 1233
Lane, Franklin Fayette, 1232
Lane, James Franklin, 641
Lane, Joseph Leon, 641
Lang, Walter William, 260
Langner, Charles A. Gottlieb Jr., 1027
La Palme, Joseph Antonio, 1027
Larson, Winford Porter, 958
Laudicina, August Peter, 959
La Victoire, Isaac Newton, 194
Law, John Harvey, 1026
Lawler, Charles Francis, 1027
Lawson, Wilson Terah, 641
Lay, Walter Siddqrs, 641
Lebedenko, Vladimir V., 52
Lebensohn, Asher Noah, 1297
Lee, Robert Louis, 495
Lemar, Fred Allard, 1027
Leslie, Thomas Everett, 642
Levin, Louis, 1027
Lewis, George Griffin, 642
Liechti, Adolf, 52
Lilling, Martin, 260
Lillard, Edward Newton, 54
Lincoln, Clarence Wyman, 1297
Linder, John, 1297
Lippmann, Mortimer, 642
Lister, Sidney Mainer, 879
Littell, Hugh Franklin, 418
Little, William H., 1297
Loechner, George Emory, 1297
Logan, Raymond W., 1166
Long, Estella Claraman, 1166
Long, Felix Benjamin Jr., 120
Long, Julian Oliver, 711
Longino, Thomas Dick, 1297
Lovejoy, Walter C., 1027
Lovell, Charles Dixon Smith, 958
Lovewell, Charles Hubart, 640
Lowman, Kenneth Earle, 417
Lulkart, John Henry, 260
Lyman, Mial R., 339
Lynn, John Roland, 879

M

McAfee, Jesse G., 958
McBride, Robert Edwin, 1233
McCain, Paul Presely, 119
McCarty, Perlee W., 642
McCleary, Wilbur Wallace, 54
McCollum, J. Riley, 339
McConnell, William Thomas, 53
McCormack, William Eli, 494
McCullough, Edward Aloysius 339
McCune, Royal Albert, 339
McDermid, Hady Calvin, 1166
McDermott, Bernard Anthony, 642
MacDonald, James Orville, 958
McElligott, Maurice James, 194
McFarland, William Smith, 1233
McFatrich, George W., 194
McGay, Norman Percy, 642
McGeachy, Robert Sherwood, 54
McGlinn, John A., 259
McGonagle, Thomas C., 1028
MacGregor, Charles, 1028
McKay, Donald Richard, 1233
McKay, Walter Wyatt, 1233
McKeldin, Robert Armand Watters, 642
McKeown, Ady Royal, 54
McKillip, William Joseph, 565
McKinley, Alfred Willits, 642
McKittrick, Charles Leroy, 642
McKnight, John Roy, 1297
McLauchlin, Thomas J., 959
McLean, John Howell, 53
MacMinn, Clarence Alfred, 642
McMullin, Francis Aloysius, 1028
McNamara, John Joseph, 642
Mahaffey, Howard Albert, 879
Mahr, Irving Oliver, 1028
Maier, Frederic Hurst, 959
Maillet, Herbert Albert, 565
Mallory, Roger Atkinson, 1166
Maltby, Burton, 1297
Manjoney, Philip, 1028
Manley, Joseph John, 339
Maps, Howard Longstreet, 1028
Marshall, Frank Fremont, 642
Martin, Francis V., 642
Martin, John Fredrick, 418
Martin, Olin Burr, 1233
Martin, William Theodore, 959
Mason, Edwin Alonzo, 565
Massengill, Samuel Evans, 959
Matousek, Frank Leslie, 1233
May, Charles Rayson, 1297
May, Raymond Victor, 1028
Meacham, William Charles, 1297
Mead, John Artemas, 1028
Mehrmann, Henry B., 340
Merriman, George Coe, 494
Mertz, Ezra Franklin, 260
Meyer, Edward Frederick, 1297
Michener, Robison R., 1028
Miller, Charles Donley, 1028
Miller, Ira Clyde, 119
Miller, Johannes Jacobus, 710
Miller, Walter Marion, 710
Miller, Wilfred Porter, 1028
Miller, William S., 260
Milligan, Samuel Cargill, 1028
Mills, William Elias, 1028
Minton, Henry McKee, 710
Mitchell, Elsie Reed, 54
Mitchell, Henry Eugene, 54
Mitchell, Stafford T., 1297
Mobley, Lewis Franklin, 340
Mock, Byron Fay, 1028
Molnar-Szakso, Helen R., 565
Moloney, Frank J., 260
Montgomery, George Wilson, 340
Montgomery, West, 340
Moore, John Claude, 1297
Moore, Nathaniel Taylor, 710
Moore, Robert Gilbert, 959
Moran, Thomas Joseph, 642
Morgan, Charles Russell, 418
Morgan, Heber Guy, 494
Morris, Benjamin Henry, 1028
Morris, Harold Arthur, 795
Morrison, Paul, 54
Moseley, Elijah Marion, 959
Mosell, Nathan F., 54
Moulton, Allen Thomas, 418
Moulton, Charles A., 565
Mount, Frank Reid, 53
Mras, John Matthew, 494
Mueller, Edward William, 565
Mullen, James Kane, 642
Mullen, Michael C., 1297
Muller, George C., 1232
Mullino, Frederick M., 879
Murphy, Henry Paul, 340
Murphy, Lew Paul, 1166
Murry, Charles Miller, 418
Musgrave, George James, 494
Myers, Charles M., 1297
Myers, Leonard Albert, 879

N

Nadig, Henry Hasswell, 1297
Nagle, Patrick Eugene, 418
Neeper, Edward Rodgers, 879
Nell, Marion Blanche, 194
Neil, Marshall Banks, 1166
Nellans, Andrew Jackson, 54
Nelson, Alvin Thomas, 260
Nelson, Ira Dorman, 119
Nelson, Ivo Amazon, 194
Nenninger, John Rudolph, 494
Newton, Guy Guerdon, 1028
Nichols, Asa Burton, 260
Nicholson, Charles Everett, 1233
Nicoll, Frederick Scoville, 710
Nigg, Henry Albert, 959
Nisbett, Frank, 1028
Nittler, Adolph Nicholas, 260
Norris, John Howard, 494
Northcutt, Eugene E., 1028
Northrop, Theodore McGeachy, 1297
Novelli, Joseph Andrew, 796
Nueske, Frederick William, 1297
Nugent, Arthur John, 879
Nutter, Harry Manlove, 340

O

O'Brien, Francis Jeremiah Vincent, 565
Ogden, George Stewart, 565
Ogden, Henry O., 260
Oglesbee, William Ernest, 1233
Ohswaldt, Herman Frederick, 54
O'Leary, Charles, 1028
O'Leary, Daniel Vincent, 710
O'Neil, Frank Church, 710
Oppenhimer, Robert P., 1297
O'Quinn, Charles Augustus, 642
Osborn, James Darrah, 1296
Osborne, Lewis N., 1028
Otte, Ray Charles, 1028
Owen, William Barnett, 1232
Owsley, Guy Mannering, 1028
Ozmun, I. Davis, 565

P

Paccione, Giovanni, 1298
Padgett, Earl Calvin, 1232
Paine, Robert Child, 260
Painter, Charles Fairbank, 1026
Palmer, Byron, 1233
Palmer, Earl, 418
Palmer, George Baldwin, 1298
Palmer, Louis Alfred, 959
Parks, Arthur Lloyd, 879
Paschall, Benjamin Stuart, 340
Patterson, John M., 54
Patterson, William Edward, 119
Paulman, George P., 54
Pearman, Thomas Benjamin, 1298
Pedicord, James M., 340
Pels, Isaac Rosenbaum, 1296
Pennington, John William, 53
Perenyi, Ladislaus Joseph, 1298
Perrigo, Willard S., 1166
Perry, William H., 54
Peters, Chester Moore, 642
Peters, John Dodge, 54
Pettit, William F., 1166
Phalen, Charles Stephen, 1298
Phelps, John Samuel, 1233
Phillips, Wilson Frank, 1298
Pickerel, Fred Beverly, 418
Piette, Eugene Constantine, 565
Pinc, Otto Charles, 194
Pinguely, Julius E., 796
Pitman, Harry Theron, 494
Pius, Charles, 1028
Pizzuto, Benjamin Anthony, 340
Platou, Pedro, 54
Plotz, Henry, 879
Plunkett, Flavius Ogburn, 959
Poling, James Alonzo, 565
Pollard, Augustus T., 54
Pollard, William Oscar, 119
Pollock, Lee Welsey, 1232
Powell, Rosa Caldwell Turnbull, 796
Powell, William Lightfoot, 796
Pratt, Maud Ferguson, 260
Pray, Ralph Edgar, 642
Preston, John William, 958
Price, George S., 796
Price, Robert Black, 642
Prien, Roland Henry, 1298
Prigge, Edward Reuben, 1233
Prince, Lawrence Hort, 260
Proctor, John Harvey, 959
Prosperi, Milton Hickox, 418
Protzman, Elmer S., 565
Pryor, David Gilmer, 194
Pucklitsch, Ernest Otto, 340
Purnell, Harry Selby, 640
Purves, Samuel Arthur, 565

Q

Quicksall, William Edward, 1028

R

Rach, Emil Arthur, 565
Rafter, Jack Roy Tayman, 340
Ragsdale, Claude E., 565
Randolph, James Henry, 710
Rasmussen, Carl Christian, 642
Ratliff, R. Ford, 120
Rau, Leonard Sigmund, 340
Ravitch, Michael Leo, 796
Record, Joseph, 959
Rector, Albert Ernest, 958
Reed, Ralph Wallace, 710
Reeder, Joseph C., 340
Reid, James D., 1298
Reid, John Inzer, 1298
Reid, Thomas Neely, 418
Reinhardt, Gustave H., 260
Remy, Charles Edward, 710
Reuben, Mark S., 796
Reynolds, Frederick Knox, 340
Reynolds, John Henry, 1298
Reynolds, William Weston, 1298
Rhea, Byrd Smith, 959
Riach, May Turner, 642
Riddick, Claude, 120
Riddle, Joseph Bennett, 1298
Rider, Clement J., 1298
Rieck, Walter Robert, 494
Rieckhoff, Frederick Arthur, 120
Riley, Edwin Almiron, 1233
Rinehardt, Stacy Herman, 1298
Rinehart, John Henry, 494
Rinne, John I. Jr., 340
Ristine, Warren Henry, 565
Ritter, John Franklin, 1298
Rivers, Walter A., 54
Robb, David N., 340
Robins, David, 796
Robinson, Victor, 1232
Rogers, Sherman T., 1298
Rohlfing, Louis C., 1166
Rokeach, Aaron, 642
Roney, Hugh Beverly, 1298
Roseberry, Eugene C., 494
Rosenbaum, Morris, 1298
Rosenfeld, Joseph, 340
Ross, Charles Clifford, 642
Ross, Gerry Weedon, 1298
Roth, Oswald Herman, 1298
Roth, Paul, 260
Rubinstein, Harry, 120
Rushing, Stancill W., 642
Ruth, Edwin Z., 959
Ryerson, William Wellington, 565

S

St. Clair, Charles Tiffany, 418
Salmon, William John Garvey, 340
Sampson, John Albertson, 710
Sanderson, Raymond, 710
Sargent, George W., 194
Sarubbi, Paul Francis, 340
Sater, Chester L., 494
Saul, Charles Dudley, 1298
Sautter, Carl Marion, 338
Saye, Joseph H., 959
Scalson, Herman, 642
Schaefer, Anton Henry, 194
Scheffer, Lunera R., 54
Schepeler, Cortlandt Whitehead, 194
Scherer, Philip Harrison, 1298
Scherrer, Elmer A., 565
Schilling, Walter, 710
Schleiter, Howard Gustav, 1232
Schoen, Philip H., 959
Schofield, Hugh Robert, 959
Seaburg, Elmer Walfred, 711
Sedwitz, Samuel Harold, 565
Segura, Joseph Otto, 194
Seidlitz, George N., 418
Seifert, Mathias Joseph, 1298
Semerak, Joseph, 642
Senn, William Nicholas, 796
Shannon, Hugh Murdoch, 1298
Sharp, Wilfrid Dooris, 418
Shearer, Thomas Laidlaw, 642
Sheehey, John Joseph, 120
Shefferd, Jeannette M., 194
Shelton, Bennett Marion, 1298
Shepard, Oscar Henry, 120
Sherbon, Amos, 1233
Shirar, Lewis, 54
Shirley, Harold Clinkscales, 494
Shoemaker, Samuel Anise, 418
Sholty, Lloyd Otterbein, 642
Short, Francis Jerome, 418
Shoun, John Bell, 958
Sigman, Frederick Grant, 54
Siler, William Stacy Jr., 711
Simard, Adelard, 796
Simmonds, Frederick Joshua, 1233
Simpson, George Franklin, 1166
Simpson, Walter B., 959
Sinclair, William Ewing, 959
Sirles, Wayne Pulley, 711
Sivyer, Allen Walter, 1233
Slate, Wesley C., 711
Smisson, Roy Clayton, 711
Smith, David Herman, 120
Smith, Edwin M. Sr., 260
Smith, Eugene Albert, 1233
Smith, Howard Hazlett, 642
Smith, Michael, 642
Smith, Milton Hamilton, 54
Smith, Richard Curtis, 418
Smith, Richard Gilchrist, 1028
Smith, Richard Manges, 1028
Smith, Roswell Haydn, 1298
Sneed, Carl Milner, 494
Snider, Joseph Scott, 494
Snowden, Charles C., 194
Snyder, Henry Galen, 959
Sparhawk, Sam, 1028
Sperry, Frederick Edward, 959
Spiegelberg, Edward Henry, 1298
Spigler, Otto Ransom, 340
Spitz, Eugene Aaron, 959
Spotswood, Dillon J., 1028
Sprague, Fred Alvah, 711
Squire, Allce Adele, 711
Srebnik, Philip, 418
Stabler, Lloyd Jesse, 1166
Stack, Eugene Anthony, 119
Stanley, William S., 120
Starkel, Charles Henry, 1026
Starr, James Oscar, 340
Stearns, Claude Adams, 796
Stegmeier, Joseph Augustus Jr., 959
Steinke, Carl Rossow, 710
Stephens, Luke B., 879
Stern, David Henry, 194
Stewart, Marshall Bruce, 1233
Stickley, Albert Edward, 1298
Stitt, John J., 565
Stitzel, Jonas Wakefield, 418
Stokes, Lydia Webster, 1298
Stoll, Henry Godfred, 1166
Stone, George Henry, 958
Streuter, Louis Warren, 120

V 1
194

Deaths—Continued
Strong, Rae Latham, 194
Stroud, Edward Clayton, 120
Stuart, H. A., 1028
Sturgeon, George Brinton, 796
Suffron, Benjamin Franklin, 260
Sundt, Mathias, 120
Sweeney, Joseph John, 494
Swiney, Merrill Alpheus, 711
Synovec, Emil, 959

T

Talley, Dyer Findley, 1026
Tarnutzer, Benjamin Charles, 642
Taylor, George Lyman, 1233
Taylor, J. Ernest, 260
Teeter, Edmund Hershey, 260
Templeton, Frederick Glenn, 642
Terrell, Allen Price, 1166
Thatcher, Allen Horatio, 54
Thomas, Clarence Manley, 1298
Thomas, Dale Edward, 494
Thomas, John Joseph, 340
Thomas, Lewis Adam, 1166
Thompson, George A., 1166
Thompson, James Isaac, 260
Thompson, Joseph, 796
Thompson, Robert C., 1166
Thompson, Robert V., 1166
Thompson, Samuel Alexander, 879
Thomson, John William, 194
Thoren, Olga C., 796
Thornley, Roy Anson, 711
Thornton, Sir Edward, 492
Thorpe, Byron Burns, 711
Thurman, Joseph Charles, 959
Tibby, Thomas Gordon, 54
Ticen, W. E., 796
Tidwell, William Flint, 1233
Tierney, Charles Matthew, 711
Tilden, Irving Niles, 260
Timberlake, Robert Edward, 120
Timberman, Andrew Jay, 193
Todd, Lucius Newton, 959
Tolson, William Alonzo, 340
Tomer, Charles Judson, 418
Trapp, Claude W., 1028
Trawick, George Connor, 796
Trible, John Metcalf, 1233
Troy, Edward Patrick, 120
Twyman, George Thomas, 54
Tynan, Joseph Patrick, 260

U

Underwood, Dora Evangeline Judson, 1166
Urbach, Erich, 711
Utley, Ralph Emerson, 711

V

Vajda, Adalbert B., 711
Valentine, Edwin James Glass Jr., 418
Van Cleave, William Edgar, 260
Van Pelt, Roscoe Samuel, 340
Van Reed, Earl, 54
Van Valzah, Robert, 417
Verdier, Charles Edwin, 340
Verne, Victor Ernest, 711
Vogt, Benedict Jr., 711

W

Wagner, James Frederic, 120
Wagner, Otto, 120
Waite, Robert Lester, 1298
Walker, George William, 260
Walker, Hasseltine Stephens, 54
Wallace, John William, 418
Walsh, Joseph P., 340
Walsh, Thomas Gervase, 1233
Walters, John Carroll, 711
Warner, Carden Frederick, 796
Warner, John William, 54
Warren, Wilber Lloyd, 120
Watson, Henry Benjamin, 1028
Weber, Louis, 120
Weddington, James L., 418
Weeden, Allen Augustus, 1298
Wehn, Clifford Charles, 418
Weir, Edward Andrew, 879
Welbourne, Edythe Winn, 1166
Welch, Stewart H., 259
Wells, George S., 796
Wells, Jacob Allen, 1028
Werner, Josef, 54
Werner, Richard Frank, 418
West, Frank Bryant, 260
West, Fred Donnell, 796
West, Henry Walker, 260
West, Jabez William, 120
Westerhout, Charles Edward, 494
Wheeler, Howard Pleas, 959
White, Abraham E., 796
White, Charles M., 796
White, Herbert Q., 1298
Wilde, Charles Fenwick, 492
Wilde, George David, 120
Wiley, Frank A., 959
Wilkens, John Albert, 53
Wilkinson, Alfred D., 418
Wilkinson, John G., 1028
Wilkinson, Richard E., 54
Williams, Charles B., 54
Williams, Joel Govan, 796
Williams, Lester Leo, 418
Wilson, Anna Louisa, 260
Wilson, Frank W., 194
Wilson, John Williams, 796
Wilson, Oscar Hermon, 418
Wilson, Richard Shelby, 711
Wilson, Roy Edward, 260
Winslow, Graven Fields, 418
Winslow, William Henry, 1166
Wolf, Arthur, 711
Womack, Alfred Arthur, 260
Woody, William Harvey, 1166
Woolsey, Calvin Lee, 418
Wright, Charles Osborne, 54
Wyker, Calvin Homer, 796

Y

Yarbrough, Cecil Sentell, 260
Yavorsky, William Daniel, 417
Yeaney, Gillespie Blaine, 1298
Young, James Archibald, 260
Youngue, Eugene L., 796

Z

Zimmerman, George Homer, 565
Zuckerman, David, 1028

133
947

E

EAGLEBURGER, L. S., personal, 1020
EAGLETON, W. P., request A. M. A. separate editorship and general management, 1923, [Fishbein] *931
EAR: See also Deafness; Hearing; Oto—
complications of streptomycin therapy, [Fowler & Seligman] *87
external meatus, suppurations, urea for, [Williams] 428—ab
Middle, Infection of: See Otitis Media
neurolabyrinthitis and congenital anhidrosis, [Helweg-Larsen] 354—ab; 895—ab
plugs to prevent traumatic deafness, 1174
Ringing in: See Tinnitus aurium
symptoms in typhus, [Merel] 1318—ab
tumors, cholesteatoma, medication to dissolve, 900
tympanic membrane perforation, closure, 280
EARNINGS: See Fees; Income; Wages
EASTMAN Institute provides free dental care to children, Stockholm, 712
Lecture: See Lectures
Radiant Energy Lamps, 1008
EATING Places: See Restaurants
Utensils: See Cooking and Eating Utensils
EATON, WILLIAM E., replies to men not allowed to resign from Navy Medical Corps., (Joint Committee report), 44
ECLAMPSIA, treatment, [Whitacre & others] *145
weather changes and, [Sapelka] 894—ab
ECONOMICS, MEDICAL: See also Insurance, sickness; Medical Service
A. M. A. Bureau of Economics Research: See American Medical Association
PHYSICIANS' DESK REFERENCE, [Rothschild] 124—C
ECZEMA, atypical lichen planus, [Wilson] 200—ab
Contact: See Dermatitis venenata
fatty acids and, [Hansen] 1240—ab
of hands from food allergy, [Rowe] 720—ab
sensitivity to soap in, [Beek] 895—ab
EDEMA: See also Ascites
of anterior part of body in mumps, [Chrysanthis] 354—ab
research, Mo., 413
EDITORS, Annual Conference of: See American Medical Association, Annual Conference
American Association of Medical Editors, [Fishbein] *240
medical, consults his readers, [Wiprud] 624—ab
EDUCATION: See also Children, school; Schools; Students; Teachers
Health Education: See Health
Higher: See University
UNESCO, Paris conference, 342
U. S. Department of Health, Education and Security: See Taft-Fulbright Bill
EDUCATION, MEDICAL: See also Schools, Medical; Students, Medical; University
A. M. A. Annual Congress on, (program) 34—E; 59; (proceedings) 856—OS
A. M. A. Council on: See American Medical Association
course in geriatrics, Buenos Aires, 882
current problems in, [Weiskotten] *1045
curriculum, proposal to shorten, Sweden, 421
curriculum, reform, Japan, 196
EDUCATION, MEDICAL—Continued
Fellowships: See Fellowships
financing, 1158—E
graduate, Michigan Postgraduate Clinical Conference (1st), 413
graduate, of physician veterans, 944—OS
graduate, *Postgraduate Medicine*, 1025
graduate program successful at Yale, 253
Graduate School: See Schools, Medical, graduate
history of, in 1884, [Fishbein] *241
in Norway, 263
Internship: See Interns and Internships
number of J.A.M.A. (1st) 1896, [Fishbein] *468
plan of all-time clinical instruction in, 1921, [Fishbein] *925
premedical conference, Alpha Epsilon Delta, Louisville, 258
premedical students, Puerto Rico, 51
Residencies: See Residents and Residencies
Scholarships: See Scholarships
teaching, euphemisms and equivalents in, 183—E
teaching mission (American medical) to Czechoslovakia, 546—E
teaching nutrition, 1282—E
training in applied basic sciences for resident, Council statement, 697—E; 717
tribute to young physician and, by Brig. Gen. Bliss, 481—E
EFFORT: See also Exercise; Work
Angina of: See Angina Pectoris
cerebral hemorrhage and muscular exertion, 1320
Syndrome: See Asthenia, neurocirculatory
EFFUSION: See Pleurisy
EGGS of flies, number, 668—ab
EISENHOWER, DWIGHT, lack of doctors is Army's chief problem, 1015
ELDERLY: See Old Age
ELECTRIC: See also Electro—; Photoelectric
High Frequency Apparatus Treatment: See Diathermy
shock, amount to cause fetal death? 280
shock (fatal), first electrocution of criminals in 1891, [Fishbein] *386
shock, steep wave electroplexy, [Strauss] 894—ab
shock treatment, [Holbrook] 65—ab
shock treatment, of psychoneuroses, [Milligan] 68—ab
shock treatment plus insulin shock in schizophrenia, [Polatin] 726—ab
Transcription for Radio Program: See Radio
ELECTROCARDIOGRAM: See Heart
ELECTROCOAGULATION: See Diathermy
ELECTROCOMA: See Electric shock treatment
ELECTROCUTION: See Electric shock (fatal)
ELECTROENCEPHALOGRAPHY: See Brain
ELECTROMYOGRAPHY: See Muscles
ELECTRONICS, The Diode, The Triode (motion picture review), 802
ELECTROPYREXIA: See Fever, therapeutic
ELECTROTHERAPY: See Electric shock treatment
ELECTROTHERMY: See Diathermy
ELI-606 Capsules, 568—BI
EMBALMING of Lenin's body, 1235
EMBLEMS: See Insignia
A. M. A. Seal: See American Medical Association Council
EMBOLISM: See also Thrombosis
large, in penicillin therapy in endocarditis, [Frada] 354—ab
pulmonary, 55
pulmonary fatal, in battle casualties, [Hamilton] 572—ab
pulmonary, prognosis; treatment, [Leriche] 429—ab
pulmonary, surgically removed foreign body embolus, [Welin] 138—ab
pulmonary, treatment, 578
pulmonary treatment: dicumarol, interrupting femoral vein and vena cava, thrombectomy; phlebotomy, [Allen & others] *1268
pulmonary (venous) air, vs. pulmonary arterial, 1276—ab
treatment, heparin in Pitkin menstruum, [Loewe & Hirsch] *1263
EMERGENCY hospital and ambulance centers, Los Angeles, 1227
EMESIS: See Vomiting
EMETINE hydrochloride treatment of ameblasis, 1042
treatment in pyogenic infections, [Melchior] 503—ab
EMIGRANTS: See Immigrants
EMOTIONS: See also Melancholia; Psychosomatic Medicine
child development center, N. Y. C., 637
different weight responses to same provocation, [Johnson] 1238—C
EMPIRE: See British
EMPLOYEES: **EMPLOYMENT**: See Industrial Health; Medicolegal Abstracts at end of letter M
Opportunities for Physicians: See Physicians, positions open
United States: See United States
EMPYEMA, treatment, intrapleural penicillin for, [Callahan] 138—ab
tuberculous, surgical treatment, [Harbitz] 142—ab
ENCEPHALITIS: See also Encephalomyelitis; Meningoencephalitis
epidemic, in military personnel; isolate Japanese B virus on Okinawa; diagnosis; use of mouse brain vaccine, [Sabin] *281
Hemorrhagic: See Poliencephalitis
virus types, arthropod-borne, [Meyer & Eddie] *827
ENCEPHALOMENINGITIS: See Meningoencephalitis
ENCEPHALOMYELITIS, equine, purified vaccine, 940—E
infantile toxoplasmic, 853—E
virus or Guillain-Barré syndrome, [Wolf] 344—C
ENCEPHALOMYELOPATHY with Icterus: See Kernicterus
ENCEPHALOPATHY, Wernicke: See Poliencephalitis
ENCEPHALOSIS, dynamite, [Gerle] 142—ab
ENDAMEBA histolytica Infection: See Amebiasis; Colitis, amebic; Liver histolytica, penicillin effect on, [Knoll] 1242—ab
ENDARTERITIS obliterans, lumbar sympathectomy in, [Van Ouwerkerk] 652—ab
ENDOANEURYSMORRHAPHY, intrasaccular obliterative, for arteriovenous fistula, [Heringman & others] *666

ENDOCARDITIS, bacterial, 174—ab
bacterial, and vitamin K, [Lutembacher] 1172—ab
bacterial, from Streptococcus s. b. e., [Loewe] 62—ab
bacterial, of tricuspid valve, [Karotkin] 139—ab
bacterial, penicillin treatment, large embolism during, [Frada] 354—ab
bacterial, subacute, cellular recovery after penicillin treatment, [Moore] 724—ab
bacterial, subacute, penicillin for, [Massell] 203—ab
bacterial, subacute, penicillin plus p-aminohippurate and heparin for, [Loewe] 61—ab
bacterial, subacute, penicillin treatment, effect of anticoagulants, [Priest] 427—ab
gonococcic, penicillin for, [Myers] *1205
ENDOCRINE GLANDS: See also Hormones; under names of specific glands
Basic Endocrines nostrums, 422—BI
factors in female sterility, [Rubin] 726—ab
fellowship for study of, by Ayerst, McKenna and Harrison, 258
research grants in endocrinology by National Research Council, 118
therapy in male sterility of nonendocrine origin valueless, [Weisman] 198—C
therapy in myasthenia gravis, 1252
ENDOMETRIOSIS, [Fallon] 351—ab
of uterus, [Spatt] 129—ab
pregnancy and, 436
treatment, conservative surgery, [Beecham] 425—ab
ENDOMETRIUM, Aberrant: See Endometriosis
cancer, vaginal smear, practical value, [Meigs] *75
ENDOTRACHEAL TUBE, value, [Foregger] *1200
ENERGY: See also Effort; Work
Atomic: See Atomic Energy
conservation of, 587—ab
Metabolism: See Metabolism, basal
Release from Food (motion picture review), 717
required for each nerve impulse, 693—ab
Value of Food: See Calories
ENGLAND: See also British; Royal
Anglo-French medical cooperation in West Africa, 195
at War: See World War
ENGLISH (language), doctors urged to use "plain English," 1015
grammar-rhetoric indicator in mental patients, [Mayer] 725—ab
ENLISTED Men or Women: See World War II
ENTERIC Fever: See Typhoid
ENTEROGASTRONE, in peptic ulcer, [Greengard] 1307—ab
ENURESIS: See Urine incontinence
ENZYMES: See also under names of specific enzymes
digest for chemical debridement of burns, 811
EOSINOPHILIA in malignant tumors, [Isaacson] 1171—ab
Transitory Infiltration of Lungs: See Loeffler's Syndrome
tropical, or pulmonary acariasis, [Hall] 967—ab
EOSOPHILIC GRANULOMA: See Granuloma
EPHEDRINE sulfate, N.N.R., (Miller) 543
sulfate treatment of myasthenia gravis, 1252
EPIDEMIC Jaundice: See Liver inflammation (infectious)
EPIDEMICS: See also under names of specific diseases as Diarrhea; Pneumonia
International Epidemiologic Reporting Service by World Health Organization, 258
Prevention: See Immunization; Vaccination
EPIDERMIS: See Skin
EPIDERMOID (cholesteatoma), medication to be used in ear to dissolve, 900
EPIDIDYMITIS, treatment, streptomycin, 855—E
EPILEPSY, clinic, Wayne County Society approves, Mich., 792
pregnancy relation to: also menstrual epilepsy, [Burnett] 1037—ab
treatment, hydantal, [Von Hagen] 889—ab
treatment, tridione; mesantoin, [Lennox] 130—ab
EPINEPHRINE, action mechanism, [Staub] 353—ab
platinum chloride or gold chloride followed by, in tattooing cornea, [Knapp] 358
treatment of splenomegaly, 73
EPISTAXIS: See Nose hemorrhage
EPITHELIOMA, Chorioepithelioma: See Chorionic Carcinoma
EPIZOOTIC Aphthae: See Foot and Mouth Disease
EPONYMS, against, [Wolf] 344—C
EQUIPMENT: See Apparatus; Medical Supplies
ERB-Goldflam's Disease: See Myasthenia gravis
ERECTIONS: See Priapism
ERGONOVINE and posterior pituitary compatible in same syringe? 1044
ERGOTAMINE, dihydroergotamine (D.H.E.45) treatment of migraine, [Pollock] 502—ab
tartrate (gynergen) treatment of migraine, 812
ERIODICTYOL glucoside: See Vitamins P
ERSKINE, National Committee for Employment of Handicapped, 46—OS
ERUPTIONS: See also Urticaria; under names of specific diseases as Erysipelas; Measles; Rickettsialpox; Scarlet Fever
fixed, from sulfadiazine, [Cole] 720—ab
Occupational: See Industrial Dermatoses
ERYSIPELAS-like eruptions, recurrent, between toes, 655
recurrent, 1043
ERYSIPELOID, [Macaulay] 139—ab
ERYSIPELOTHRIX infection, [Ehrlich] 571—ab
ERYTHEMA: See also Lupus erythematosus
multiforme exudativum in pneumonia, [Dingle & others] 888—ab
Nodosum (Valley Fever): See Coccidioidomycosis
ERYTHREMIA: See Polycythemia
ERYTHROBLASTOSIS in adults, [Nordenson] 504—ab
ERYTHROBLASTOSIS, FETAL, artificial termination of pregnancy for, 479—E
kernicterus in, [Vaughan] 203—ab
pathogenesis, [Wiener] 885—ab
pathogenesis, and Rh antibodies in newborn and, [Hill] 201—ab
Rh isoimmunization, [Philpott] 1035—ab
ERYTHROCYTES, agglutination by mononucleosis serums, [Burnet] 67—ab
changes in severe burns, [Brown] 1315—ab
Count: See Anemia, Pernicious; Polycythemia
rouleaux formation (excessive) in multiple myeloma, [Bayrd & Heck] *151
Sedimentation: See Erythrocytes
Sickling: See Anemia, sickle cell
virus receptor gradient [Burnet] 67—ab
ERYTHROLEUKEMIA: See Osteosclerosis myelofibrosis
ESCHERICHIA coli infection of urinary tract, streptomycin for, [Adcock & Plumb] *579
ESOPHAGUS, cancer, food restriction vs. doctor's order, England, 341
cancer of middle third, new operation for, [Lewis] 207—ab
cicatricial obliteration, subtotal esophagectomy in, [Sweet] 205—ab
electrocardiogram, [Butterworth] 885—ab
obstruction from congenital vascular ring, [Sweet] 1310—ab
tumors, leiomyoma, successful resection, [Shafer & Kittle] *1202
ESSAY Contest: See Prizes
ESTROGENIC SUBSTANCES, androgen ratio disorder, swelling of breast in men, 146
Diethylstilbestrol: See Diethylstilbestrol
lability of bone, mobilization of minerals and salts from skeleton, 110—E
ointments containing (Council report), 1009
solution of estrogens (in oil), N.N.R., (Miller) 543
treatment of prostate cancer, [Ferguson] 69—ab; [Weidlandt] 503—ab
treatment of prostate cancer with ethinylestradiol, [McCrea] 965—ab
vitamin B complex suppress estrogenic function in women? 1253
ESTROVIN in Oil, 883—BI
ETHER and humbug, [Graham] *97
Diethyl: See Diethyl Ether
treatment (injection) of hiccup, 810
ETHICS, MEDICAL, advertising by physicians, [Fishbein] *938
fee splitting and rebates, [Fishbein] *609; *768; *933; [Patek] 715—C
medical journals and, P. Maxwell Foshay on, 1900, [Fishbein] *534
physician acting as locum tenens for colleague in hiding during the war, Denmark, 123
physicians relationship to cultists, [Fishbein] *100; *175; *924; *933
PRINCIPLES OF MEDICAL ETHICS, history of, [Fishbein] *103; *241; (in 1898) *388; (attacks on) *391; (revised and adopted in 1903) *609; *611
responsibilities of German medical profession for atrocities; (A. M. A. Judicial Council report on Dr. Ivy's account) 35; [Wertham] 645—C
ETHINYL estradiol for prostate cancer, [McCrea] 965—ab
ETHYL AMINOBENZOATE, prolonging action of local anesthetics with benzocaine, 496
tetra ETHYLAMMONIUM ion in peripheral vascular disease and causalgia, [Berry] 66—ab
ETHYLENE DICHLORIDE (dichloroethane), 577
di ETHYLSTILBESTROL: See Diethylstilbestrol
6-ETHYL-THIOURACIL, thiouracil derivatives in hyperthyroidism, 544—E
EUDOLAT: See Meperidine
EUGENICS, are we becoming less intelligent as result of dysgenic breeding? 961
program, Japan, Population Policy Commission, 185—OS
EUPHEMISMS and equivalents in teaching and practice, 183—E
EUPHORIA, habituation to demerol hydrochloride, [Curry] *243
EVIDENCE: See also Medicolegal Abstracts at end of letter M
A. M. A. resolution on expert witnesses, 1882, [Fishbein] *238
EXAMINATION: See American Board; Health, U.S.P.H.S.; Physical Examination
EXAMINING BOARD: See Specialties
EXANTHEMS: See Eruptions
EXCERPTA Medica: See Journals
EXERCISE: See also Effort; Golf; Work
effect on incidence of bends, [Burkhardt & others] *375
for bedridden patients, physicians accused of neglecting, 699—OS
Therapeutic: See also Orthoptics
therapeutic, for palate after bulbar poliomyelitis, 434
EXERTION: See Effort
EXFOLIATION: See Dermatitis exfoliativa
EXHIBIT: See also American Medical Association, Scientific Exhibit; Pasteur
showing conquest of disablement, 566
EXOPHTHALMIC Goiter: See Goiter, Toxic
EXPECTORANTS, cough syrup, [Boyd] 716—C
EXPERIMENTATION: See Animal Experimentation; Research
EXPERT Witness: See Evidence
EXPLOSIVES: See Dynamite; trinitrotoluene
EX-SERVICE MEN: See Veterans
EXTREMITIES: See also Arms; Foot; Legs
Amputation of: See Amputation
Blood Supply: See Raynaud's Disease
muscular cramps and pain in parkinsonism, 280
Paralysis: See Paraplegia
ulcers, powdered human blood cells for, [Anderson] 885—ab
EYEGLASSES: See Glasses
EYELIDS, diagnosis of blepharoconjunctivitis, 900
diagnostic value of changes in margins in conjunctivitis, [Thygeson] *437
"Granular Lids": See Trachoma
Sties on: See Sty
EYES: See also Blindness; Cornea Glasses; Ophthalmology; Retina; Uvea; Vision
Bank for sight Restoration (fellowship), 492
bank, Stanford University establishes, 873
burns from chemicals, [Cruthirds] 131—ab; [McLaughlin] 719—ab
changes in blood dyscrasias [Tassman] 1306—ab
congenital papillary melanosis, 714
Disease: See also Conjunctivitis; Glaucoma; Keratoconjunctivitis; Trachoma
disease, autonomic nervous system in, [Harrington] 719—ab
disease, cytral for, 1235
disease, grave eye disease, Behcet's syndrome, [Thomas] 1246—ab
disease, scholarships for study, New York, 50; 637
herpes zoster, meningoencephalitis after vaccination for, [Madonick] 133—ab
intraocular pressure, gonlotomy for glaucoma; [Barkan] *526
manifestations of psychosomatic disorders, [Harrington] *669
mercury deposited in, [Abramowicz] 352—ab
movements (fusion), motor component of retinal stimuli, 713
Muscles: See Orthoptics
penicillin injected into, [Van Heuven] 70—ab
penicillin (pure) use in, [Sorsby] 428—ab
EYESIGHT: See Vision

F

FABRICS: See Clothing; Rubber
FACE: See also Cheek; Eyes; Jaws; Mouth; Nose; etc.
bony defects, reconstruction, [Macomber] 649—ab
Creams: See Cosmetics
hyperhidrosis, 507
hyperhidrosis (unilateral frontal), supraorbital nerve section for, [Tarlow & Herz] *476
Paralysis: See Paralysis
tumors, angiomas, treatment (reply), [Ronchese] 578
FACTORY Workers: See Industrial Health
alpha-FAGARINE, toxicity, 196
FAINTING: See Syncope
FAIRYFOOT for Bunions, 568—BI
FALLOPIAN TUBES: See Oviducts
FAMILIES: See also Children; Infants; Marriage; Maternity; and under names of diseases as Ductus Arteriosus; Glycogen disease
intelligence level fluctuates with size of, 961
FARMERS: See also Rural Communities
medical service program and, [Goss] 778—ab
shoveler's disease, [Wetzel] 652—ab
thresher's disease, [Hoffmann] 652—ab
thresher's lung, [Tornell] 504—ab
FASCIOLOPSIS buski infection, treatment, 900
FASTING: See Starvation
FAT: See also Acid, fatty; Butter; Obesity
brown fat extracts, effect on basal metabolism, 436
diet high in, effect on bends, chokes, etc. [Burkhardt & others] *374; *376
diet high in recovery from infectious hepatitis, [Hoagland] 499—ab
diet with sucrose or lactose, value, [Ershoff] 1304—ab
food restriction vs. doctor's order in esophagus cancer, 341
organs, primitive, 1283—E
vegetable, value for growth, [Basu] 68—ab

V 1
194

FATIGUE: See Asthenia, neurocirculatory; Neurasthenia
FECES, blood in, probable gastrointestinal tract lesion, 378
Fistula: See Fistula
Loose Stools: See Diarrhea; Dysentery
FECUNDATION: See Impregnation
FEDERAL: See United States
Control of Medical Care: See Medicine, state
Income Tax: See Tax
Legislation: See Laws and Legislation, federal and state (weekly summary)
Sickness Insurance Scheme: See Wagner-Murray-Dingell Bill
Workers: See United States employees
FEDERATION: See Societies at end of letter S
FEEDING: See Diet; Food; Nutrition
of Infants: See Infants
FEES: See also Income; Wages
for locum tenens, Denmark, 123
new, for Dutch doctors, 1300
splitting, A. M. A. resolution on, in 1902, [Fishbein] *609; (in 1913) *768; (also on rebates, 1924) [Fishbein] *933
splitting and rebates, [Patek] 715—C
FEET: See Foot
FELLOWSHIPS: See also Scholarships
American College of Physicians, research fellowships for 1947-1948 awarded, 492
A. M. A.: See American Medical Association
Ayerst, McKenna and Harrison, for study of internal secretions, 258
Eye Bank for Sight Restoration, 492
Heed Ophthalmology Foundation, 1230
in diabetic research established, Pa., 50
in public health, New York State, [Amos] 124—C
Jacobi (Mary Putnam), for medical research, 51
programs must provide for training in applied basic sciences, Council decree, 697—E; 717
Rosenstock Memorial Foundation, Inc., 955
Royal College: See Royal College of Surgeons
Schenley Distillers, in industrial medicine at U. of Pittsburgh, 638
Trubek, in rheumatic disorders, N. Y., 49
FELON: See Paronychia
FEMUR, fracture of neck after irradiation of uterine cancer, [Kulseng-Hanssen] 574—ab
fractures of neck, [Boyd] 1308—ab
fractures of neck, vitallium mold arthroplasty in, [Smith-Petersen] 1308—ab
FERMENTS: See Enzymes
FERROUS: See Iron
FERTILITY: See also Reproduction; Sterility
are we becoming less intelligent as result of dysgenic breeding? 961
FERTILIZATION: See Impregnation
FETUS: See also Infants, Newborn; Placenta; Pregnancy
blood, oxygen pressure gradient between maternal blood and, [Barron] 207—ab
bones of, in bladder from ectopic pregnancy, [Forshaw] 429—ab
death, amount of electric shock to cause, 280
death, continuous caudal anesthesia cause of, [McCormick] 801—C
Erythroblastosis: See Erythroblastosis
hyperplasia of islets of Langerhans in, of diabetic mothers, [Hultquist] 1318—ab
Rh Factor in: See Rh Factor
respiration (intrauterine), [Windle & Becker] 1:5—C
sulfonamides effect on, 970
FEVER: See also Rheumatic Fever; Rocky Mountain Spotted Fever; Scarlet Fever; Typhoid; Typhus
Aphthous: See Aphthous Fever
Canicola: See Leptospirosis canicola
effects of antipyretic drugs on measles eruption, 508
Glandular: See Mononucleosis, Infectious
headache in, [Scott] 574—ab
Japanese River: See Tsutsugamushi Disease
Malta: See Brucellosis
Parrot: See Psittacosis
Q: See Q Fever
Rabbit: See Tularemia
Relapsing: See Relapsing Fever
Therapeutic: See also Malaria, therapeutic
therapeutic, plus penicillin in neurosyphilis, [Rose & Solomon] *6
Undulant: See Brucellosis
Valley: See Coccidioidomycosis
FIBRIN, fibrinogen plastics, tissue reactions induced by, [Bailey] 721—ab
foam in suprapubic prostatectomy, [Quinby] 203—ab
FIBRINOLYSIS, [Macfarlane] 805—ab
FIBROBLASTOMA, perineural (neurinoma) of facial nerve, [Kettel] 63—ab
FIBROMYOMA: See Myoma
FIBROMYOSITIS and referred pain, [Slobe] 803—ab
FIBROSIS: See Pancreas
of Bone Marrow: See Osteosclerosis myelofibrosis
FILARIASIS, treatment, lithium antimony thiomalate, [Brown] 268—ab
FILMS: See Microfilms; Moving Pictures; Photography; Roentgen Rays
FINGERS: See also Nails; Toes
amputation of tip, new method [Kutler] *29
amputations, tendon sutures in, 358
FINGERNAILS: See Nails
FIRE: See Burns
FIRST AID kit, Schaffner's "Little Doc" Jr., 883—BI
FISHBEIN, MORRIS, appointment in 1913 as assistant to editor, *769; (appointment as editor, 1924) *935
FISTULA, anal, nonoperative treatment, 435
arteriovenous, repair; evaluate 3 operative procedures [Herlngman & others] *663
fecal, after appendectomy, 1254
intestinovesical, [Barnes & Hill] *456
vesicovaginal, apparatus to control urinary incontinence due to [Castallo] *244
FITNESS: See Physical Fitness
FLATULENCE, decompression sickness, [Burkhardt & others] *373; [Behnke] *451
FLAX spider, bite, [Grille Cendan] 69—ab
FLEMING, ALEXANDER, Albert Medal to, 878
FLEXNER Lecture: See Lectures
FLIERS: See Aviation
FLIES, control conference, Ia., 954
control, danger of DDT in hospital kitchens and dining rooms, 73
eggs, number of, 668—ab
FLIGHT: See Aviation
FLOOD, typhoid vaccine given after, Ill., 1227
FLORITONE, 264—BI
FLOUR: See Bread
"FLU": See Influenza
FLUIDS: See also Coffee: Milk; Water
Body: See also Ascites; Cerebrospinal Fluid; Saliva
body, calcium content, reducing 1043
Parenteral: See Injections
use in craniocerebral injuries, 214
FLUKE: See Fasciolopsis buski
FLUORESCENCE, detect tubercle bacilli by, technic, [Clegg] 68—ab
of nuclei after quinacrine, 1252
FLUORIDES, sodium, topical, in dental caries, [Knutson] 573—ab
urinary excretion in men in alkylation plants, [Largent] 1309—ab
FLUORINE-dental caries hypothesis, [Downs] 499—ab
dental caries research project, Evanston, 561
in water safe level, 734
Industrial hazards, [Murray] 728—ab
FLUOROSIS in cattle, industrial hazard, [Murray] 728—ab
industrial, [Green] 353—ab
FLY: See Flies
FLYERS: Flying: See Aviation
FOCAL Infection: See Infection
FOLIC Acid: See Acid
FOLLICULITIS, penicillin for, [Hopkins] 886—ab
FOOD: See also Bread; Butter; Cereal Products; Diet; Fruit; Meat; Milk; Nutrition; Restaurant; Vegetables; Vitamins
allergens, recurrent vesicular eruption of hands, [Flood] 892—ab
allergy, dermatitis of hands due to, [Rowe] 720—ab
A. M. A. Council on: See American Medical Association
Appetite for: See Appetite
cadmium lined containers, danger, [Monnet] 729—ab
Deficiency: See Nutrition deficiency
efficiency of animals to produce human food, [Maynard] 202—ab
Energy Release from (motion picture review), 717
Energy values: See Calories
habits and dental caries, [Neumann] 1037—ab
handlers, course for, (Wash.) 793; (N. Y.) 1228
handlers, gastroenteritis aboard ship, 777—E
handlers, school for, Ga., 489
Infants': See Infants, feeding
Lack of: See Starvation
needs survey, Japan, 559
Poisoning: See also Gastroenteritis
poisoning after Christmas party, Chicago, 412
poisoning from cream pies, Mich., 792
poisoning, Norway withdraws embargoed sardines, N. Y., 50; 877
ration of U. S. Army, cost increases 32%, 789
rationing, delivery scheme for aged to diminish overcrowding of hospitals, 643
rationing vs. doctors order in esophagus cancer, 341
selection and taste in hypoglycemia, [Mayer-Gross] 573—ab
service supervisors, 47
U. S. Food and Drug Acts: See Medicolegal Abstracts at end of letter M
U. S. Food and Drug Administration, deaths from Analbis Suppositories, 852—E; [Weinstein] 962—C
U. S. Food and Drug Administration, Notice of Judgment: See under American Medical Association Bureau of Investigation
U. S. food and drug legislation, 1892, [Fishbein] *386
U. S. Food, Drug and Cosmetic Act, amend requiring salt be iodized, 620—E; 1161
U. S. Pure Food Law, amending urged by A. M. A., [Fishbein] *765
FOOT: See also Footprints; Orthopedics; Toes
founder a disease of horses resemble human gout? 434
recurrent erysipelas-like eruptions 655
FOOT AND MOUTH DISEASE, funds required for study of, in Mexico, 788—OS
FOOTPRINTS of newborn, permanence, [Walker] 1032—C
FORCE: See Energy
FOREIGN BODIES, embolus in pulmonary artery, surgically removed, [Welin] 138—ab
FOREIGN COUNTRIES: See United Nations; under names of specific countries as Belgium; China
FORMALDEHYDE, stability of penicillin solutions treated with, 420
FORMULARY: See also Pharmacopeia
National, published, 52
FOSHAY, P. MAXWELL, on medical ethics and medical journals, [Fishbein] *534
FOUNDATIONS, American, for High Blood Pressure, 117
Childs (Jane Coffin) Memorial Fund for Medical Research, 1231
Commonwealth Fund, (annual report) 638
Georgia Warm Springs, 1163
Gould (Robert) Research, training in nutrition, 708
Heed Ophthalmology, fellowships, 1230
Hematology Research, 412
Hodgkin's Disease Research Foundation organized, 708
Levy (Joseph), for research on hypertension, 490
Life Insurance Research Fund awards for research, 957
Luzier's allergy research fund given to American College of Allergists, 1294
Mayo, (Dr. Victor Johnson accepts appointment to) 327—OS; (American Pharmaceutical Manufacturers Ass'n award to) 337
Meek (Walter Joseph) Fund for superior students, 492
Menninger, research grants, Kans., 792
Mott, grant for graduate study, 413
National Foundation of Infantile Paralysis, (March of Dimes) 117; 185—OS; (research director: H. M. Weaver) 257; (research meeting) 492; (grant for training medical record librarians) 622—E; 639; (grant for National Mental Health, educational program, 1230
research on muscle physiology) 792
National Science Foundation, 180—E; 184—OS; 328—OS; 357—OS; 1161
Nuffield, gift for research in geriatrics to Cambridge, 1234
Oklahoma Medical Research, 414
Plotz (Ella Sachs) grant for research, 416
Psychiatric, formed, 878
Riggs (Austen) medical director, 792
Rockefeller, (terminates grants to Peiping Union Medical College) 564; (grant to Center for Scientific Research, France) 960; (appropriations) 1294
Rosenstock Memorial, Inc., fellowships, 955
Seaman (Louis Livingston) Fund, (research in bacteriology and sanitary science), 415
Sugar Research, prize for research on sugar, 52
FOUNDER, disease of horses, resemble human gout? 434
FOURTH OF JULY accidents, report in 1903, [Fishbein] *610
FRACTURES: See Femur; Ribs
FRAGILITAS ossium (osteogenesis imperfecta) 434; 656
FRAMBESIA, treatment, penicillin, [Hill] 69—ab
FRANCE: See French
FRAUDS: Fraudulent Salesman: See Impostors
FRENCH Academy of Surgery, foreign members elected, 1234
Anglo-French medical cooperation in West Africa, 195
Congress of Medicine, to meet Oct. 1947, 1234
Ministry for Public Health allotted streptomycin by U. S. government, 1234
FRONTAL Lobe Leukotomy: See Brain, surgery
FRUIT: See also Lemon juice; Pears; Pineapple
citrus industry, dermatitis in, [Seidmann] 1248—ab
FRUITOLA and Traxo, 422—BI
FUADIN treatment of tuberculosis, [Rose] 269—ab
treatment of schistosomiasis in Leyte reoccupation, [Winkenwerder] 1242—ab
FULBRIGHT-Taft Bill (S. 140): See Taft-Fulbright Bill
FUND: See Foundations
Loan: See Students, Medical
FUNGI: See Mold
Infections of: See Mycosis
FURACIN soluble dressing, in dermatology, [Downing & others] *299; (sensitivity to) [Morin] 963—C
FURUNCULOSIS: See also Carbuncle
treatment, bacitracin, [Meleney & Johnson] *675
treatment, penicillin, [Hopkins] 886—ab
FUSOSPIROCHETOSIS: See Angina, Vincent's

G

G. I. Bill of Rights, 406—OS
GALACTOSE tolerance in epidemic hepatitis, [Schmiderbaur] 1172—ab
GALLAHER, E. B., pyogen, spray as "cold cure," (Joint Council report), 694
GALLBLADDER: See also Bile; Bile Ducts
calculi, acute calculous cholecystitis in children, [Clavel] 895—ab
calculi, anything that will dissolve them clinically? 146
calculi, first operation for, by Dr. J. S. Bobbs, [Fishbein] *683
calculi or colic, reliable past history in jaundice, [Snell] *1176
calculi, surgical hazards, [Muir] 894—ab
excision, diet and medication after, 213
inflammation, complicates typhoid in child, [Sepulveda de Borquez] 1247—ab
inflammation, surgical hazards, [Muir] 894—ab
roentgen study, 508
roentgen study, comparative, [Frank] 804—ab
GALLSTONES: See Gallbladder calculi
GANGLION, gasserian, Kirschner electrocoagulation of, 577
GANGRENE, incidence, vascular injuries affecting, [Thomas] 650—ab
treatment, diethyl ether, [Wirtschafter & Widmann] *604
GARFIELD, JAMES A., case history by Dr. Reyburn, [Fishbein] *389; *390
GAS: See under names of specific gases as Oxygen
Embolism: See Embolism, pulmonary
Mustard: See diChlorоethyl Sulfide
Pain: See Flatulence
Poisoning: See Carbon monoxide
GASOLINE, Ethyl: See Lead
GASTRECTOMY: See Stomach surgery
GASTRIC: See Stomach
Ulcer: See Peptic Ulcer
GASTROENTERITIS: See also Food poisoning aboard ship, 777—E
GASTROENTEROLOGY, Sociedad de Gastroenterologia y Nutricion, 343
GASTROINTESTINAL TRACT: See also Abdomen; Intestines; Stomach
lesion, probable, 278
GELATIN sponge, hemostatic dressing in anorectal surgery, [Rosser] 893—ab
GELSEMIUM in preparalytic poliomyelitis, [Holman] 136—ab
GENERAL PARALYSIS: See Dementia Paralytica
GENITALS: See also Penis; Vagina
pathologic findings in menopausal bleeding, [Check] 425—ab
tuberculosis (latent) as cause of sterility, [Halbrecht] 69—ab
tuberculous primary infection, [Bjørnstad] 1248—ab
ulcer, grave eye disease with, Behcet's syndrome, [Thomas] 1246—ab
GEORGETOWN University, Dr. Marchetti heads gynecology-obstetrics dept., 948—OS
GEORGIA Warm Springs Foundation: See Foundations
GERBER'S Ready to Serve Barley Cereal, 937
GERIATRICS: See Old Age
GERMAN atrocities, Dr. Ivy's report on, A.M.A. Judicial Council report, 35
atrocities, ethical responsibility of medical profession, [Wertham] 645—C
medical research, unpublished, 416
occupation, physician acted as locum tenens for colleague in hiding, Denmark, 123
GERMAN MEASLES: See Rubella
GERMICIDES: See Sterilization, Bacterial
GERMS: See Bacteria
GESTATION: See Pregnancy
GIARDIASIS, treatment, quinacrine hydrochloride, 74
GIBBS Memorial Prize: See Prizes
GIDDINESS: See Vertigo
GIFFORD Lecture: See Lectures
GIFTS: See Donations (cross reference)
GIRDLES: See Corsets
GIRLS: See Adolescence; Women
GLANDERS, human, 599—ab; 622—E
GLANDS: See also under names of specific glands interscapular or hibernating, of Merkle; primitive fat organs, 1283—E
of Internal Secretion: See Endocrine Glands
GLANDULAR FEVER: See Mononucleosis, Infectious
GLASS, fiber, clothing, 900
GLASSES, contact lenses, [Case] 722—ab
prescribing, rebates to ophthalmologist, [Patek] 715—C; [Fishbein] *933
GLAUCOMA, congenital, early diagnosis; goniotomy for, [Barkan] *526
manifestations of psychosomatic disorders, [Harrington] *672
National Society for Prevention of Blindness prize for paper on, 258
GLIOMA: See Retinoblastoma
GLOBIN Insulin: See Insulin
GLOBULIN, antihemophilic, 1044
human, use in treating virus conjunctivitis and superficial punctate keratitis, 508
of varicella convalescents to treat herpes zoster, 55
GLOMERULONEPHRITIS: See Nephritis
GLOSSITIS: See Tongue inflammation
GLOVES, Rubber: See Rubber gloves
GLUCONATE, ferrous, harmful effect of prolonged administration, 655
GLUCOSE: See Dextrose
GLUCURONATE Excretion Test: See Liver function
GLYCEMIA: See Blood sugar; Diabetes Mellitus
GLYCERIN-saline-acetic acid mixture for chemical debridement of burns, 811
GLYCERYL TRINITRATE, treatment of angina pectoris; effect of age, [Sagall] 271—ab
GLYCINE: See Acid, aminoacetic
GLYCOGEN disease, [Crawford] 728—ab
disease, familial, [Abramson] 570—ab
GLYCOLS, vapors for disinfecting purposes; use of glycostat, 696—E
GLYCOSURIA, diagnosis (differential) 278
pseudoglycosuria, in patients treated with penicillin, [Boldyreff] 715—C
renal, 435; 899
GÖBELL-Stockel's Operation: See Urine incontinence
GOITER: See also Goiter, Toxic; Hyperthyroidism
endemic, due to lack of iodine? [Greenwald] 891—ab
iodized salt and; pending legislation; A.M.A. Council decision on, 620—E
GOITER, TOXIC, in middle aged and elderly, [Whishaw] 352—ab
treatment, aminothiazole (abadol), [Perrault] 353—ab
in men, [Larsen] 274—ab
treatment in pregnancy, 655
treatment, methyl thiouracil, [Poate] 1172—ab
treatment, propylthiouracil, [Reveno] *1190
treatment, radioactive iodine, [Hertz] 726—ab
treatment, thiouracil, N.N.R., (description) 619; (Abbott; Parke Davis; Rorer; Squibb; Winthrop) 619
GOLD chloride plus epinephrine for cornea tattooing, (reply) [Knapp] 358
colloidal, liver function test, Borowskaja method for, 734
dermatitides, BAL for [Ragan & Boots] *752
dermatitis exfoliativa from, 507; 733
poisoning, BAL for, [Cohen & others] *749
poisoning, BAL for thrombopenic purpura and granulocytopenia, [Lockie & others] *754
GOLDEN Key Antiseptic Medicated Cream, 568—BI
GOLF, American Medical Golf Association, annual tournament, 631—OS
GONADOTROPINS, chorionic, growth promoting agents, 898
chorionic, Choriogonin, N.N.R., [Lakeside] 1281
GONADS: See Ovary; Testis
GONIOTOMY for congenital glaucoma, [Barkan] *526
GONOCOCCUS Endocarditis: See Endocarditis
Infection: See Gonorrhea
GONORRHEA: See also Endocarditis, gonococcic; Venereal Disease
in children, penicillin for [Wiederhold] 70—ab
incidence in men, vs. circumcision, [Wilson] 1245—ab
treatment, increasing chemoresistance, [Nørgaard] 1248—ab
treatment, penicillin, in women, [Debray] 895—ab
treatment, penicillin, (parenterally) [Meads] 426—ab; (orally) [Bushby] 574—ab; 961
treatment, penicillin (tablets buffered), N.N.R., (description) 851; (Abbott; Bristol; Schenley; Squibb) 851
treatment, streptomycin, 855—E
GOODPASTURE, E. W., research and medical progress, 400—E
GORGAS memorial, 1923, [Fishbein] *931
GOULD Foundation: See Foundations
GOVERNMENT: See State government; United States
Control of Medicine: See Medicine, state
Hospitals: See Hospitals
GRADUATES courses; etc.: See Education, Medical
Fellowships: See Fellowships
GRADUATES: See Interns and Internships; Residents and Residencies
GRAFT: See Adrenals; Bones; Cartilage; Skin; Transplantation (cross reference)
GRAIN: See also Cereal Products
mite infestation of urinary tract, [Crance] 1243—ab
GRAMMAR-rhetoric indicator in mental patients, [Mayer] 725—ab
GRAND Mal: See Epilepsy
GRANTS for Research: See Fellowships; Foundations; Research; University
GRANULAR Lids: See Trachoma
GRANULOCYTOPENIA: See Agranulocytosis, Acute
GRANULOMA Coccidioidale: See Coccidioidomycosis
eosinophilic, of bone, [Dundon] 273—ab; 1284—E
eosinophilic, of bone, relation to xanthomatosis, 776—E
Fungoides: See Mycosis fungoides
infectious, lesions of cervix, [Guerriero & others] *832
inguinale, demonstration of Donovan bodies, [Lyford] 723—ab
inguinale, false positive reactions for syphilis after tropical diseases, 73
inguinale of cervix uteri, [Guerriero & others] *833
intestinal, of dysenteric origin, [Silverman & Leslie] *994
Malignant: See also Hodgkin's Disease
malignant, of nose, [Hargrove] 140—ab
talc, [Lichtman] 206—ab
GRAVES' Disease: See Goiter, Toxic
GREAT BRITAIN: See British; England; Royal; World War II
GREEN, FREDERICK R., assistant to secretary, 1910, [Fishbein] *762; (resignation, 1922) *927
GREEN, R. D., personal, 790
GREEN, Janus, titration of streptomycin by quick method, 960
GRIFFITH, J. G., JR., pitressin for hypertension, 898
GRIP: See Influenza
GROUP Hospitalization: See Hospitals, expense
Insurance: See Insurance
Practice; Group Clinics: See Medicine, group practice
GROW, MALCOLM C., (John Jeffries award to) 408; (promotion) 1018
GROWTH: See also Bones; Cretinism
promoting agent in butter: vaccenic acid, 1299
promoting agents, 898
value of butter fats and vegetable fats for, [Basu] 68—ab
GUANIDINE treatment of myasthenia gravis, 1252
GUERRIERO Lectureship: See Lectures
GUERRY, LeGRAND, bronze plaque, S. C., 793
GUILLAIN-Barré Syndrome, treatment, neostigmine against eponyms, [Wolf] 344—C
GUMS: See Jaws; Teeth
GUT: See Catgut
GYNECOLOGY, Congress on (6th), Argentine, 343
International Congress of, to be held July 7, 416
Jane Todd Crawford Student Loan Fund in, 1230
Sociedad Ycateca de Obstetricia y Ginecologia, 418
GYNERGEN: See Ergotamine tartrate

H

HAEMOPHILUS: See Hemophilus (cross reference)
HAIR: See also Beard; Scalp
Loss of: See Alopecia
picric stain, removal, 734
HAKANSSON, ERIC G., U. S. Navy assignments, 488
HALDANE, J. B. S., lecture by, 331
HALL, JAMES L., to resume private practice, 112—OS
HALLUCINATIONS, hypnagogic, 1253
HALLUX valgus (bunions): See Toes
HAMBY'S Dawson Springs Water, 568—BI
HAMILTON, JOHN B., editor of J. A. M. A., [Fishbein] (1888-1889) *316; *317; (again in 1893; brief biography) *389; (death) *473
HAND: See also Fingers; Nails; Wrist
artificial, model, 408
atopic dermatitis, from food allergy, [Rowe] 720—ab
tendon transplantation in, [May] 206—ab
vesicular eruption (recurrent), [Flood] 892—ab
HANDICAPPED: See also Disability; Physical Defects
civilians, model center for rehabilitation, 327—OS
National Committee for Employment of, 46—OS
Veterans: See Veterans, disabled
HARNESS, restraining, for aircraft pilots, [Bierman & others] *522
HARRIS, MALCOLM L., acts as editor of J. A. M. A. during Dr. Simmons' absence [Fishbein] *769
HARRISON, L. W., retirement of great venereologist, 566
HARRISON Narcotic Law, 1915, [Fishbein] *837
HARVEY Lecture: See Lectures
HASKELL, CHARLES C., & Co., assay of thiamine in Pantabee, [Haskell] 645—C

HAWLEY, PAUL R., (medical chief criticizes Legion for opposition to medical reforms) 699—OS (lectures at Naval Medical Center) 703; (warns medical work in VA perilled by lack of funds) 787—OS
HAY FEVER, antihistamine drugs and hypertension, 812
pollen desensitization during pregnancy contraindicated? Similar allergy in child? 1174
HAYDEN'S Carmelized Wheat Germ, 264—BI
HEAD: See also Brain; Cranium; Face; Hair; Neck; Scalp
Bald: See Alopecia
injuries, cerebellar subdural hydroma, [Grant] 889—ab
injuries, electroencephalogram in, [Laufer] 724—ab
injuries (minor), vertigo after; cause; treatment, 434
Lice: See Pediculosis
Pain: See Headache
tremor, cataract surgery in patient with, 278
HEADACHE: See also Migraine
after spinal anesthesia, vitamin B1 for, [Bazzocchi] 430—ab
Costen's syndrome and head pain, [Bell] 208—ab
dynamite encephalosis, [Gerle] 142—ab
febrile, [Scott] 574—ab
treatment, nicotinic acid, 1044
HEALERS, Drugless: See Cults
HEALING: See Wounds
HEALTH: See also Disease; Hygiene; Sanitation
activities in Latin America, 118
atomic energy and, [Lyon] 725—ab
Board of: See Health, department; Health, state board
Center: See also Medical Center
center, definition (Reference Committee report), 36
center for rural areas, [Weagley] 781—ab; [Davis] 866—ab; (Committee report), 860—OS
center of the world, Bethesda becoming, 482—OS
challenge of our schools, 696—E
Child Health Day: May 1st, 1219—OS
Clauses: See Industrial Trade Unions
conditions reported by Gen. MacArthur, Japan, 252
council as agency to promote rural health, committee report, [Jones] 864—ab
Council of Greater New York, N. Y., 706
department of Chicago closes restaurants, 252; 875
department of New York City (80th year), 116; (annual report), 256; (closes 5 restaurants) 1229
departments consolidate, Ill., 1227
departments (county), 17 counties vote for, Ill., 334
departments (state), in 1872, [Fishbein] ★102
departments (state), reorganize, Minn., 562
districts, Connecticut Medical Society supports establishing, 412
education by American Red Cross, 1289
education conference, N. Y. C., 414
education, school, W. Va., 491
Examination: See Physical Examination
French Ministry for Public Health allotted streptomycin by U. S. government, 1234
Fund: See Industrial Trade Unions
in aging population, 414
Industrial: See Industrial Health
Insurance: See Insurance, sickness
International Health Congress, Puerto Rico, 1230
legislation beneficial to the people A. M. A. resolution on, 40
Mental: See Mental Hygiene
museum, Cleveland, 1024
National Advisory Health Council, (membership) 790; (medical research grants recommended by) 1289
National Conference on Health in Colleges (3rd), 1217—E
National Health Agency, 855—E; 868—OS
National Health Bill (Taft-Smith-Ball-Donnell): See Taft
National Health Congress, (Reference Committee report) 36; (expands program) 639
National Health Program, Bill to Provide: See Wagner-Murray-Dingell Bill
National Health Service Act (Beveridge Plan; British "White Paper"): See National Health Service Act
National Institute of, (activities) 702; (Council discusses) 851
National Negro Health Week, March 30-April 6, 708
nursing center opened in Chinatown, N. Y., 876
of Recruits: See World War II
of the people and hospitals, [Parran] ★1047
officers (local), qualifications revised, N. Y., 190
Organization of United Nations: See Health, World Health Organization
planning for, by Senator Taft and President Truman, 180—E
program, state aid for, N. Y., 335
Program, Voluntary: See Wagner-Murray-Dingell Bill
HEALTH—Continued
project in A. M. A. Bureau of Health Education, 945—OS
projects, planning, FWA funds for, 793
public, Buenos Aires, 882
public, field of, [Green] 627—ab
Public Health Education Committee of Women, 1910, [Fishbein] ★762
Public Health Institute closes its doors, Chicago, 334
Public Health Nurses; Nursing: See Nurses; Nursing
public, positions open, New York State, [Amos] 124—C
public, request A. M. A. to publish periodical on, [Fishbein] ★762; ★766
public, training program for physicians, (Illinois) 255; (Kansas) 561
public, Tulane U. offers degree in, 561
referendum, Italy, 881
resorts, American, A. M. A. Committee activities referred to A. M. A. Council, 936
Rural: See Rural Communities
School: See Schools
Service: See also Health centers; Health, National Health Service; Medical Service
service and research at Los Alamos project, 115
services (child), study by American Academy on Pediatrics, (A. M. A. Reference Committee report), 40
services, investigation in South Australia, 1031
state boards, [Fishbein] ★175; ★176
Statistics: See Vital Statistics
Supplies: See Medical Supplies
survey, (Cook County) 49; (7 cities, Calif.) 791
UNRRA health division closes, 638
U. S. Department of, advocated by A. M. A. in 1888, 1891, [Fishbein] ★315; ★386; ★387; ★769; ★926
U. S. Department of Health, Education and Security (Fulbright-Taft Bill), 180—E; 185—OS; 398—E; 482—OS; (Joint Committee report) 943—OS; (A. M. A. position on) 1015; (conclusion of hearings) 1159—OS
U. S. Dept. of National Health (Miller Bill) 185—OS
U. S. Department of, with cabinet officer, [Kilsti] 1032—C
U. S. P. H. S., (release of medical officers, Joint Committee report) 45; (seeks new medical research center) 45—OS; (125 Army medical officers released to) 46—OS; (examinations for appointments) 114; (organization for nationwide medical research) 187; (examinations for appointment of nurses) 253; (examinations for regular corps) 253; (Federal Employees Health Division) 409; (Examination for appointment of pharmacists) 409; (cancer survey) 482—OS; (seeks 50 million dollars to start hospital construction) 556—OS; (annual report) 702; (3 national health councils; membership) 790; (conference on BCG vaccination) 1158—E; (survey of medical profession in Washington, D. C.) 1159—OS; (survey of medical groups in U. S.) [Dickinson] ★1222; (headquarters moved to Social Security Building) 1289; (list of officers released from service) 1289; (venereal disease pamphlets by) 1294
Units: See Health centers
Welfare Programs: See Industrial Trade Unions
World Health Organization, (Calderone heads Interim Commission) 117; (international epidemiologic reporting service by Interim Commission) 258; (outline of work) 405—OS; (constitution, USPHS annual report) 702; (constitution expected to be ratified) 788—OS; (Interim Commission meets March 31) 956; (joint resolution providing for membership and participation by United States) 1221—OS; (allocate UNRRA funds to) 1231
HEARING: See also Ear
aids, Bellone Harmony Mono-Pac, 543
aids, course in audiometry and fitting, Iowa, 1292
aids, Maico atomeer, 542
aids, Trimm vacuum tube, 542
impaired, after streptomycin therapy, [Fowler & Seligman] ★87
Loss of: See Deafness
rehabilitation, (center opened, D. C.) 408; (program, Illinois) 561
HEART: See also Arteries, coronary; Cardiovascular system
anomalies, anastomosis of systemic artery to pulmonary artery for blue baby, 248—E
anomalies, congenital pulmonic valve stenosis, surgery for, [Fine] 426—ab
Auricular Fibrillation: See Auricular Fibrillation
block (complete) from digitalis, [Wagener] 200—ab
course in cardiology, Wis. 51
Disease: See also Endocarditis
disease (congenital), arterial anastomosis for blue baby, 248—E
disease (congenital), surgical treatment, [Fashena] 893—ab
disease, Herrick House for convalescent children, Ill., 636
HEART—Continued
Disease (Hypertensive): See Heart insufficiency
disease, rheumatic, clinic (5th) established, Pa., 336
disease, rheumatoid arthritis, [Rogen] 1315—ab
disease, sclerogenic, from avitaminosis B1, [Bianchi] 430—ab
disease, sudden deaths of young soldiers, 321—E; [Moritz] 721—ab
disorders in polyarthritis, [Applegren] 895—ab
electrocardiogram changes, [Sensenbach] 348—ab
electrocardiogram changes due to inanition, [Forster] 730—ab
electrocardiogram, esophageal, [Butterworth] 885—ab
electrocardiogram in Besnier-Boeck-Schaumann's disease, [Leitner] 730—ab
electrocardiogram in hypertension, [Filley] 270—ab
electrocardiogram in malignant diphtheria, [Giraud] 353—ab
electrocardiogram in peptic ulcer [Øyning] 208—ab
electrocardiography (direct) in restored human heart after death, [Andreyev] 431—ab
Failure: See Heart insufficiency
hypertrophy and acromegaly, [Schornagel] 1172—ab
in severe anemia, [Gelfand] 651—ab
insufficiency, diet low in salt and sodium in congestive failure, [Wheeler & others] ★16; (early work of Hermann Strauss in 1902) [Gossels] 497—C
insufficiency, familial incidence of failure, [von Rechenberg] 141—ab
Insufficiency, prophylactic digitalization, 508
insufficiency, renin in failure, [Merrill] 424—ab
insufficiency, sudden death, pathologic anatomy, [Munck] 968—ab
insufficiency, 2-thiouracil for congestive failure [Sharpey-Schafer] 805—ab
Inter-American Congress of Cardiology (2nd), 639
Irritable: See Asthenia, neurocirculatory
lesions in pulmonary tuberculosis, 567
Muscle: See Myocarditis; Myocardium
National Heart Week, Feb. 9-15, 563
Neurosis: See Asthenia, neurocirculatory
Output: See Blood circulation
Rate: See also Tachycardia
rate, humoral transmission of vagal and accelerator effects, 761—ab
Rhythm: See Arrhythmia
size, roentgen determination, [Denstad] 1038—ab
Valve: See Mitral Valve; Pulmonary Valve; Tricuspid Valve
HEARTBURN in pregnancy, [Roth] 427—ab
pyrosis, [Schepers] 127—ab
HEAT: See also Burns; Fever; Steam; Tropics
Production: See Metabolism, basal
Therapeutic Use: See also Diathermy; Fever, therapeutic
therapeutic use, Eastman Radiant Energy Lamps, 1008
therapeutic use of (motion picture review), 802
HEED Foundation: See Foundations
HEKTOEN, LUDVIG, progress with the JOURNAL, 1895, [Fishbein] ★466
HEKTOEN Lecture: See Lectures
HELIO Minerals, 264—BI
HELPING Hand Laxative Tonic, 882—BI
HEMATEMESIS, peptic ulcer incidence in, (Cluer) 274—ab
probable gastrointestinal lesion, 278
HEMATOCRIT values in wound shock, [Stewart] ★216
HEMATOLOGY: See Blood
Research Foundation: See Foundations
HEMATOPOIESIS: See Blood formation
HEMATOPORPHYRINURIA: See Porphyria
HEMOGLOBIN: See also Methemoglobinemia
blood carboxyhemoglobin in aviators, [Pitts] 1304—ab
etiology of chloroma and nature of green pigment, [Humble] 729—ab
in late pregnancy and puerperium, 1254
values in women workers, [Davies] 728—ab
HEMOGLOBINURIC FEVER, Malarial Black Water Fever: See Malaria
HEMOLYSIS: See Jaundice, hemolytic
Disease Involving, in Newborn: See Erythroblastosis, Fetal
HEMOPHILIA: See also Pseudohemophilia
antihemophilic globulin, 1044
coagulating property of blood in, [Chevallier] 353—ab
heredity of hemophiliac factor, [Weil] 1172—ab
treatment, roentgen, [Ostro] 205—ab
HEMOPHILUS ducreyi: See Chancroid
Influenzae Infection: See Influenza
HEMOPTYSIS, treatment, temporary elimination of phrenic nerve, [Stangl] 431—ab
HEMORRHAGE: See also Hemophilia; Purpura; Telangiectasia; under names of diseases and organs affected as Nose; Peptic Ulcer; Uterus

HEMORRHAGE—Continued
blood loss in operations, [Baronofsky] 1036—ab
control, hemostatic dressing in anorectal surgery, [Rosser] 893—ab
fatal allergic reaction to influenza vaccine, [Curphey] ★1062
Menstrual: See Menstruation
posttransfusion, death in infant, 811
Prothrombin relation to: See Blood coagulation; Blood prothrombin
HEMOSTASIS: See Hemorrhage control
HEMOTHERAPY: See Blood Transfusion
HEPARIN, anticoagulant and coronary thrombosis, 970
effect on penicillin in endocarditis, [Priest] 427—ab
in Pitkin menstruum for venous thromboembolic disease, [Loewe & Hirsch] ★1263
sodium, N.N.R., (description) 1009; (Abbott; Upjohn) 1009
treatment of acute coronary occlusion, 357
treatment plus penicillin and sodium para-aminohippurate in endocarditis, [Loewe] 61—ab
HEPATIC: See Liver
HEPATITIS: See Liver Inflammation
HEPATOMEGALY: See Liver hypertrophy
HEREDITY: See also Anaphylaxis and Allergy; Dystrophy, muscular; Eugenics; Myopia; Nystagmus; Retinoblastoma; Telangiectasia of hemophiliac factor, [Weil] 1172—ab
symposium on, N. Y., 1230
HERNIA, keloid, of anterior tibial muscle, (reply) [McKeever] 214
of Meninges: See Meningocele
scrotal, duration, 1044
ventral, repair, and cesarean sect. a, 507
HEROES: See also Martyrs; World War II, Heroes
typhus in research workers and others, [Sadusk] ★1194
HERPES zoster ophthalmicus, meningoencephalitis after vaccination for, [Madonick] 133—ab
zoster, treatment by globulins of varicella convalescents, 55
zoster, treatment of pain after, 733
HERRICK House for convalescent children, Ill., 636
HERZEN, PIOTR A., death, 1235
HESPERIDIN: See Vitamins P
HEXAMETHYLENAMINE: See Methenamine
HEXYLRESORCINOL, effects on surface tension of urine, [Inness-Brown] 1301—C
HIBERNATION and pituitary hypertrophy, 656
hibernating or interscapular gland of Merkle, primitive fat organs, 1283—E
HICCUP treatment: nikethamide; also carbon dioxide inhalation and ether injection, 810
HIGH Blood Pressure: See Blood Pressure
Frequency Apparatus: See Diathermy
HILL-BURTON ACT, (A. M. A. Reference Committee report), 36; (state agencies to administer) 187; (regulations for hospital survey) 560; (various authors) 860—ab; (general regulations promulgated under) 946—OS; [Parran] ★1047
HILLMAN, CHARLES G., retires, 408
HI-LO Tablets, 883—BI
HIMROD'S Asthma Powder, 883—BI
HIP: See Femur; Pelvis
HIRSCHSPRUNG'S Disease: See Colon, megacolon
HISPANO: See Spanish
HISTAMINE, Antihistamines: See also Benadryl
antihistamines, [Friedlaender] 1309—ab
antihistamines and hypertension, 812
antihistamines: Cytral, 1235
antihistamines for penicillin urticaria [Pillsbury & others] ★1255
antihistamines (3015 and 3277), 960
elaboration in vivo, in peripheral vascular disorders, [Wirtschafter & Widmann] ★604
treatment (intravenous) of prolonged reaction to benadryl, [Schwartzberg & Willerson] ★393: [David & Karr] 1301—C
treatment of allergic conditions, [Brown] 207—ab
treatment of arthritis, 212
1 (—) **HISTIDINE** monohydrochloride-sodium ascorbate injection in peripheral vascular disorders, [Wirtschafter & Widmann] ★605
HISTOLOGY: See Tissues
HISTOPLASMIN, reactors, calcifications in spleen in [High] 804—ab
sensitivity, [Christie] 202—ab
HISTORY of A. M. A.: See American Medical Association
of Medicine: See Medicine, history
HIVES: See Urticaria
HOBBIES: See Physicians, avocations
HODGKIN'S DISEASE in children, [Wright] 722—ab
Research Foundation organized, 708
HOGS: See Trichinosis
HOLLAND: See Netherlands
HOLLISTER, JOHN H., Chicago vs. Washington permanent home of A. M. A., [Fishbein] ★384; ★389
HOLMAN, ALBERT W., gift for chorionepithelioma registry, 192
HOLMES, OLIVER WENDELL, [Fishbein] (gave private library to Boston Medical School) ★317; (death of) ★392
HOME: See also Housing
danger in kitchen, 1295
HOMEOPATHY, problems, 1878, [Fishbein] ★176
HOMICIDES: See Murder
HONORABLE DISCHARGE: See World War II, medical officers released
HOOD-LAX, Dr. Parrish's frauds, 57—BI
HOOKWORM: See Ancylostomiasis
HOOVER Medal: See Prizes
HORMONES: See also Endocrine Glands
lability of bone, mobilization of minerals and salts from skeleton, 110—E
Sex: See Androgens; Estrogenic Substances; Gonadotropins
treatment of myasthenia gravis, 1252
HORSES, founder resemble human gout? 434
HOSPITALIZATION Insurance: See Hospitals, expense insurance; Medical Service Plans
HOSPITALS: See also Clinics; Medicolegal Abstracts at end of letter M
administration course at Washington U., 1163
administration program, State University of Iowa, 1163
A. M. A. Council on: See American Medical Association
Army air base, taken over by tuberculosis board, Fla., 791
Army, construction program, 1947, 47
Army Mayo General, leased to U. of Illinois, 255
Army, residencies in, ★1080
Army, streptomycin therapy in, [DeBakey] 1036—ab
Army 36th General, history, 329
Barnard Hospital Lecture: See Lectures
Beds: See also Hospitals, veterans
beds, capacity, ★1066
beds occupied, percentage, ★1073
Blessing, Adams County Medical Society resolution on policies on, Quincy, Ill., 489
Blue Cross Plans: See under Hospitals, expense insurance
Boston City Hospital Lecture: See Lectures
Building: See also Hospitals, Army; Hospitals, veterans
building fund, Pratt gift to, New York, 413
Building, Hill-Burton Act: See Hill Burton Act
building program, proposed, Puerto Rico, 336; 1165
building, report on efforts of National Grange, [Halvorson] 781—ab
building, U.S.P.H.S. seeks fifty million dollars to start, 556—OS
Cancer: See Cancer
Care: See Hospitals, service
Center: See also Medical Center
center, Washington, D. C., (Swedish hospital as model) for, 184—OS; (sites for) 250—OS
children's, ★1066; ★1072
children's classroom in, Colo., 1291
Children's Memorial, Northwestern U affiliates with, 1023
Construction: See Hospitals, building
convalescent and rest, ★1066; ★1072
Cook County, 2 year internship required, Ill., 791
cost of operating, [Buerki] 782—ab
county, new, Orange County, Cal., 636
Department for Continued Care of long term illness, [Bluestone] ★1051
emergency, and ambulance centers, Los Angeles, 1227
Employees: See Hospitals, personnel
Evanston, expands, Ill., 875
Expense Insurance: See also Medical Service Plans; Medicolegal Abstracts at end of letter M
expense insurance, Blue Cross for rural communities, [Mertz] 782—ab
expense insurance, Blue Cross, membership in, Puerto Rico, 336
expense insurance, rural enrolment experience, [Helsby] 407—OS
Facilities: See also Hospitals service
facilities and health centers for rural areas, [Weagley] 781—ab
facilities by states and by control, ★1068
facilities division, director, 708
facilities for rural areas, [Weagley] 781—ab; [Davis] 860—ab; (Committee report) 860—OS
facilities, number, size and classification, ★1066; ★1067
food delivery scheme for aged to diminish overcrowding of hospitals, 643
Government: See also Hospitals, building; Hospitals, service; Hospitals, veterans
government, facilities by states, ★1068
government plan for taking over voluntary hospitals, England, 195
Group Hospitalization: See Hospitals, expense insurance
growth, summary, 1909-1946, ★1066
Harding, opened, April 1, N. Y. C., 1164
health of people and, [Parran] ★1047
in Spain, 343
Industrial, ★1066; ★1071
Insurance: See Hospitals, expense insurance
Interns; Internships: See Interns and Internship
HOSPITALS—Continued
isolation, ★1066; ★1072
John Sealy, Texas, 1164
Kern County, investigation, Calif., 1291
Kings County, plaque to 816 war veterans, 955
kitchens, danger from DDT used to control flies, 73
licensing law, model, 946—OS
maternity, ★1066; ★1071
maternity service, births in, ★1074
Medical Service Plans: See Hospitals, expense insurance
Metropolitan, site for, N. Y., 955
Military: See Hospitals, Army; Hospitals, Naval
Naval, closes, New Orleans, 114
Naval, corps, medical administrator, 406—OS
Naval, corpsmen, Surgeon General lauds, 699—OS
Naval, residencies in, ★1080
necropsy rate (highest), 1946, ★1082
Neuropsychiatric: See Hospitals, psychiatric
number, April 12, 1947, page 1065
Number of: See Hospitals, service
nursery, diarrhea epidemic in, secondary to milk-borne epidemic, [Ensign] 271—ab
nursery, measures to protect newborn, [Weymuller & others] ★78
Nurses: See Nurses
orthopedic, ★1066; ★1072
orthopedic, new, Sitka, Alaska, 336
patients admitted 1946, ★1067
patients, average daily census, ★1073
patients, average length of stay, ★1074
Personnel: See also Hospitals, staff; Nurses
personnel, employment of practical nurses, 631—OS
personnel (technical), statistics on, ★1077; 1158—E
personnel, ward helpers, N. Y., 490
Psychiatric: See also Hospitals, state
psychiatric, ★1066; ★1071
psychiatric, American, brutalities in; vs. ethical responsibilities of German medical profession, [Wertham] 642—C
psychiatric: Franklin Delano Roosevelt, 790
psychiatric (new), Sweden, 1300
psychiatric, St. Elizabeths, (Overholser opposes transfer to D. C.) 250—OS; (status) 631—OS
Records: See Medical Record Librarians
registered by A. M. A., list of, ★1083-★1143
rehabilitation, for spastic children, 256
Residents; Residencies: See Residents and Residencies
Rochester General, centennial, 1228
St. Barnabas, for Chronic Diseases, 706
St. Luke's, bequest to, Chicago, 954
St. Luke's, U. S. Army occupies, Tokyo, 789
St. Vincent's, Alfred E. Smith Memorial Wing, 955
Service: See also Hospitals, facilities; Hospitals, maternity service; Medical Service Plans
service accommodation in Norway, 1167
service classified by control, ★1066; ★1068; ★1069; ★1070
service, committee on purchase of, 791
service, counties without, Ill., 791
service, data according to type of, ★1066; ★1071
service in U. S., ★1065; 1155—E
service, organization in Chile, 1167
Service Plans: See Hospitals, expense insurance; Medicolegal Abstracts at end of letter M
Staff: See also Hospitals, personnel
staff appointment, difficult for physician veterans to secure, (Joint Committee report) 45
staff, general practitioners on, vs. specialists, [Garlieyj] 1169—C
staff members, rules governing moral conduct, fee splitting and rebates, [Patek] 715—C
staff, physician veterans want hospitals to employ doctors with military service, 184
staff physicians strike settled, Stockholm, 421
staff salaries of junior doctors, Norway, 797
staff, shortage of doctors, 556—OS
standardization by A. M. A., 1918, [Fishbein] ★843
State: See also Hospitals, psychiatric
state, campaign to improve mental care, Ill., 561
state, Egyptian, nursing service, appalling corruption, 1299
Stockholm, (physicians strike settled) 421; (no visitors allowed), 712
Survey and Construction Act: See Hill-Burton Bill
Sydenham, emergency fund raised, N. Y., 876
USPHS, residencies in, ★1080
Veterans: See also Veterans, medical care
veterans admitted in 1946, 1020
veterans, at Tomah, Wis., 790
veterans' beds (100,000), 113
veterans, bids for, in North Dakota, 253
veteran's care program, Hawley stresses need of private hospitals in, 45—OS
veterans, delays in providing, 405—OS
veterans, Franklin Delano Roosevelt neuropsychiatric, 790

HOSPITALS—Continued
veterans, in Memphis, 488
veterans, Jefferson Barracks, 113
veterans, new contracts blocked, 1159—OS
veterans, new managers, 1289
veterans, news about, 331
veterans, plans approved, Arlington, 556—OS
veterans, proposed cancer hospital in Chicago, 253
veterans, residencies in, (work by medical schools under deans' committees) 855—E; (round-table discussion) 856—ab; *1081
veterans, site, VA asks condemnation, 871—OS
Wesley staff honors Dr. M. Goldstine, 489
HOUSING: See also Buildings; Home
living quarters for interns in Japan, 196
HOUSSAY, B. A., retirement, 196
HOXSEY, HARRY M., cancer charlatan, 774—E; (correction) 957
HUNGER: See Appetite; Starvation
HUTCHINSON, Sir JONATHAN, biography, 1029
HUZZAH, A Vitamin B_1 & B_2 Supplement, 422—BI
HYDANTAL, use in epilepsy, [Von Hagen] 889—ab
HYDATIDIFORM Mole: See Placenta tumors
HYDE, E. E., death, appointment of Dr. Fishbein in 1913, [Fishbein] *769
HYDRAPHORUS with Cinchona, 422—BI
HYDROLYSATES: See Protein
HYDROMA: See Hygroma
HYDROPHOBIA: See Rabies
HYDROSULPHOSOL, treatment of corneal and x-ray burns, [Cruthirds] 131—ab
HYDROTHERAPY (motion picture review), 802
HYDROXYCOUMARIN, Methylene Bis: See Dicumarol
HYGIENE: See Health; Sanitation
Dental: See Dentistry
Industrial: See Industrial Hygiene
Mental: See Mental Hygiene
HYGROMA, cerebellar subdural, [Grant] 889—ab
HYPERCHOLESTEREMIA: See Blood cholesterol
HYPERHIDROSIS: See Sweat
HYPERINSULINISM: See Pancreas, secretion
HYPERPARATHYROIDISM: See Parathyroid
HYPERPNEA: See Respiration, hyperventilation
HYPERNEPHROMA, bilateral, [Senger] 1311—ab
HYPERPROTEINEMIA: See Blood proteins
HYPERPYREXIA: See Fever, therapeutic
HYPERSENSITIVITY: See Anaphylaxis and Allergy
HYPERTENSION: See Blood Pressure, high
HYPERTHYROIDISM: See also Goiter
effect on alloxan and pancreatic diabetes, 195
in pregnancy, thiouracil for, 73
treatment, methyl-thiouracil, [Frisk] 574—ab
treatment, propylthiouracil, [Astwood] 500—ab
treatment, radioactive iodine, [Hertz] 726—ab
treatment, thiouracil derivatives, 544—E; [Bartels] 893—ab; [Hadorn] 967—ab
treatment, thiouracil, N.N.R., (description) 619; (Abbott; Parke Davis; Rorer; Squibb; Winthrop) 619
HYPERTROPHY: See Splenomegaly; under specific organs as Heart; Liver; Pituitary; Prostate; Thymus
HYPERVENTILATION: See Respiration
HYPNAGOGIC Hallucinations: See Hallucinations
HYPNOTICS: See Sedatives
HYPOGLYCEMIA: See Blood sugar
HYPOPHYSIS: See Pituitary
HYPOPROTHROMBINEMIA: See Blood prothrombin
HYPOTHERMIA: See Crymotherapy
HYPOTHYROIDISM: See also Cretinism
bone age studies, [Dutton] 963—ab
HYPOVITAMINOSIS: See Vitamins deficiency; under names of specific vitamins
HYPOXIA: See Oxygen deficiency
HYSTERIA, canine, and diet, [Mellanby] 805—ab
ocular manifestations, [Harrington] *673

I

ICE Anesthesia: See Anesthesia, refrigeration
local use after orthopedic procedures, [Schaubel] 269—ab
local use in leg injury, [Pernworth] 1308—ab
ICTERUS: See Jaundice
Encephalomyelopathy with: See Kernicterus Gravis: See Liver atrophy (acute yellow)
IDENTIFICATION: See also Emblems; Insignia
of newborn by footprints, [Walker] 1032—C
IDIOSYNCRASY: See Anaphylaxis and Allergy
ILLEGAL Operation: See Abortion, criminal
ILLINOIS: See Chicago
University of: See University
ILLNESS: See Disease
IMMIGRANTS, nonimmigrant entry authorized for doctors, Puerto Rico, 638
IMMUNITY: See also Antibodies; and under names of specific diseases as Influenza; Liver inflammation; Malaria; Poliomyelitis
developed to transplanted tumors, Besredka's theory, 111—E; [Gross] 800—C
IMMUNIZATION: See also Vaccination; under names of specific diseases as Influenza; Tuberculosis; Typhus
countywide, Ind., 189
for Kenya colony, 434
IMPACT decelerator, [Bierman & others] *522
IMPETIGO, treatment, bacitracin, [Meleney & Johnson] *675
IMPORTED Sea Vegetables Vitaminized with Added Vitamin A, 883—BI
IMPOSTOR, warning of: Brooks Mendell, 492
warning of: E. G. King, 1230
IMPOTENCE, barbiturates prolonged use effect on, 279
complications of spinal anesthesia, [Mason] 345—C
IMPREGNATION: See also Coitus; Pregnancy; Reproduction
artificial, preserving spermatozoa for, 900
Preventing: See Contraception
receptivity of cervical mucus to spermatozoa, [Barton] 140—ab
INANITION: See Nutrition deficiency; Starvation
INCOME: See also Fees; Wages
raised for admission to health insurance, Netherlands, 712
Tax: See Tax
INCONTINENCE: See Urine
INDEX Catalogue of Surgeon General's Library, [Fishbein] *103
INDEX MEDICUS, (financial difficulties), [Fishbein] *388; (publication discontinued, 1899) *474
Quarterly Cumulative: See American Medical Association
INDIAN Journal: See Journals
INDIANA Board of General Practice of Medicine, Inc., bylaws outline, 43; 942—OS
INDIANS, South American, medical protection of natives, Buenos Aires, 882
INDUSTRIAL ACCIDENTS, statistics for 1946, National Safety Council report, 564
INDUSTRIAL DERMATOSES, chromates cause, in aircraft workers, [Ellis] 1244—ab
citrus workers, [Seidmann] 1248—ab
cosmetic, in beauty parlor operator, 899
Japanese rifles cause, [Hinman] 132—ab
methylene dichloride (dichloromethane) and methyl chloride, 145
rubber manufacture, preventing, 1254
INDUSTRIAL DISEASES: See also Industrial Dermatoses
atabrine workers, "blue halos" of cornea in, [Mann] 1315—ab
clinic (1st), Swedish, 421
asbestosis, [Noro] 652—ab
diagnostic clinic, Pa., 1229
dynamite encephalosis, [Gerle] 142—ab
fluorine hazards, [Murray] 728—ab
fluorosis, [Green] 353—ab
hazards, bills in Congress, 406—OS
methylene dichloride (dichloromethane) and methyl chloride, 145
paper dust, 435
Pneumonoconiosis: See Pneumonoconiosis
radium poisoning, determine radium content of body to prevent, [Hess] 1305—ab
Q fever in U. S., [Topping & others] *813; [Irons & Hooper] *815; [Irons & others] *819; Fox & others] *820
shoveler's disease, [Wetzel] 652—ab
Silicosis: See Pneumonoconiosis
thresher's disease, [Hoffmann] 652—ab
thresher's lung, [Tornell] 504—ab
tuberculosis hazard in medical students, [Morris] 62—ab
INDUSTRIAL HAZARD: See Industrial Diseases
INDUSTRIAL HEALTH: See also Industrial Hygiene
advancement of, (Joint Committee report), 44
A. M. A. Council on: See American Medical Association
clinics, Racine, 877
conclave at Buffalo, 1165
conference at Williamsport, Pa., 956
employ nation's disabled, 1219—OS
Federal Employees Health division of U. S. P. H. S. established, 409
fibromyositis and referred pain, [Slobe] 803—ab
group insurance as it affects the physician, [Rees] *613
hospitals, statistics, *1066; *1071
influenza B vaccination in factory, in [Norwood] 1307—ab
management-physician conferences, 706
maternity leave for federal workers, 185—OS
medicine, department, Mich., 792
medicine fellowship by Schenley Distillers at U. of Pittsburgh, 638
National Committee for Employment of Handicapped, 46—OS
physical examinations (pre-employment, occupational hazard, maintenance), [Poole] *91
physician industrial management conferences, 706
pyogen, spray promoted as "cold cure," (Joint Council report), 694
tuberculosis survey, Chicago, 489
tuberculous patients reeducation and apprenticeship of, 263
200,000 Americans are potentially unemployable each year through disablement, 788
INDUSTRIAL HEALTH—Continued
urinary fluoride excretion in employees in alkylation plants, [Largent] 1309—ab
workers output and caloric intake, 322—E
workers (women), hemoglobin values in, [Davies] 728—ab
INDUSTRIAL HYGIENE: See also Industrial Health
service, Ohio, 491
INDUSTRIAL INJURIES: See Industrial Accidents
INDUSTRIAL POISONING: See Industrial Dermatoses; Industrial Diseases
INDUSTRIAL TRADE UNIONS, A. M. A. resolution on Bituminous Coal Mine Wage Agreement, 35
health welfare programs in labor-management agreements, 327—OS; [Dickinson] *1285
labor attempts to coerce nurses and physicians to, England, 121
mine operators term Lewis health and welfare fund "economic blackmail" 556—OS
sickness benefits plans, [Dickinson] *1285
United Mine Workers Health Fund (A. M. A. Reference Committee report), 36; [Dickinson] *1285
INEBRIETY: See Alcoholism
INFANTILE PARALYSIS: See Poliomyelitis
INFANTILISM, Renal: See Osteodystrophy, renal
INFANTS: See also Children; Infants, Newborn; Pediatrics; under names of specific diseases
"blue babies," arterial anastomosis for, 248—E
Death: See Infants, mortality
diarrhea epidemic, Mass., 489
diarrhea in breast fed, St. John's bread plus carrots for, [Rohmer] 729—ab
feeding, advertising proprietary foods 1915, [Fishbein] *837
feeding, Beech-Nut products, 937
feeding (breast) by mother with brucellosis during pregnancy, 357
feeding (breast), failure of, 341
feeding (breast), nursing by syphilitic mother, 810
feeding, cards available for physicians interested in, W. Va., 116
feeding, Gerber's Ready to Serve Barley Cereal, 937
feeding, intravenous alimentation, [Dodd] 893—ab
feeding, Libby's strained products, 937
methemoglobinemia from bismuth subnitrate used for diarrhea, [Wallace] *1280
methemoglobinemia from nitrates in well water, [Faucett] 271—ab
mortality, fatal plastic bib, 121
mortality, posttransfusion death, 811
mortality rate decreased, U. S., 416
negroid characteristics in, 280
truncus arteriosus in, [Taussig] 1303—ab
Weight: See Infants, Newborn, weight
INFANTS, NEWBORN: See also Fetus
Birth Rate: See Vital Statistics
blood group tests, [Davidson] 345—C
circumcision of, (reply), [Rosenthal] 436
diarrhea epidemic, [Rubenstein] 1311—ab
diarrhea epidemic secondary to milk-borne epidemic, [Ensign] 271—ab
Erythroblastosis in: See Erythroblastosis, Fetal
footprints, permanence, [Walker] 1032—C
infectious mononucleosis in, acquired before birth, [Trincao] 142—ab
kernicterus in, [Vaughan] 203—ab
Nursery: See Hospitals, nursery
Ophthalmia in: See Conjunctivitis, infectious acute
protection; measures at Long Island College Hospital, [Weymuller & others] *78
Test-tube: See Impregnation, artificial
tetanus from infected talc, fatal to 3, Australia, 1031
weight gain, relation to maternal weight gain, [Klein] 129—ab
INFECTION: See also Bacteria; Immunity; Pneumococcus; Staphylococcus; Streptococcus; Virus
air borne, control, [Perkins] 1304—ab
autoinfection (experimental), Russia, 713
factors in spreading in nursery for newborn, [Weymuller & others] *78
Focal: See also Tonsils, infected
focal, Dr. Irons' presidential address on, 111—E
mixed, intrapleural penicillin for, [Callahan] 138—ab
of Blood: See Meningococcemia
Postoperative: See Infection, surgical
Prevention: See Sterilization, Bacterial
Pyogenic: See Abscess
surgical, bacitracin locally, [Meleney & Johnson] *675
surgical, penicillin for, [Meleney] 426—ab
Wound: See Wounds, infected
INFECTIOUS Hepatitis: See Liver inflammation
Mononucleosis: See Mononucleosis, Infectious
INFECTIOUS DISEASE: See also Epidemiology; Immunity; Immunization; Vaccination; and under names of specific infectious diseases in pregnancy; defects in child [Swan] 1316—ab
INFERTILITY: See Sterility

INFLAMMATION: See under names of specific diseases and organs as Bladder; Gallbladder; Pancreas; Stomatitis; Tongue
INFLUENZA, A and B, where obtain antiserum to measure antibodies in patient's serum, 810
B epidemic in Pacific area, 1945, [Milstone] 725—ab
B epidemic, vaccination in industrial plant, [Norwood] 1307—ab
B in 1945-1946, Great Britain, [Dudgeon] 274—ab
B incidence, effect of vaccination on, 940—E
B, specific and nonspecific reactions to, [Burnet] 140—ab
epidemic, human, protective antibodies, 882
immunization 161—ab
immunization, agglutination inhibition test in, [Florman] 128—ab
immunization at Duke U., [Broadbent] 204—ab
in Illinois, mild type, 875
in Sweden, 564
incidence, U. S., 1025
Index, [Schwartz] 350—ab
meningitis related to bacterial type, outcome, [Zinnemann] 894—ab
meningitis, streptomycin for, [Hoyne] 721—ab
of Parrots: See Psittacosis
treatment, whisky, in 1920, [Fishbein] ★924
vaccine, fatal allergic reaction, [Curphey] ★1062
vaccine, safe to use in tuberculosis patients? 1174
vaccine, Sweden, 421
vaccines, comparative prophylactic value of different ones, 146
viruses, toxicity [Henle] 648—ab
INFRA-RED RAYS, Eastman Radiant Energy Lamps, 1008
INFUSION: See Injections, intravenous
INGALS, E. F., first A. M. A. home at 535, [Fishbein] ★668
INHALATION: See Carbon Dioxide; Steam of Dust: See Pneumonoconiosis
INJECTIONS: See also under names of specific substances
Intravenous: See also Anesthesia, pentothal; Liver extract; Blood Transfusion
intravenous alimentation in infants, [Dodd] 893—ab
intravenous infusion in dehydration, [Borst] 968—ab
Spinal: See Anesthesia, spinal
INJURIES: See Accidents; Burns; Trauma; Wounds; under specific organ or region as Brain; Eyes; Liver; Spinal Cord
Industrial: See Industrial Accidents
War: See World War II, casualties
INOCULATION: See Immunization
INSANE ASYLUMS: See Hospitals, psychiatric; Hospitals, state
INSANITY: See Dementia Paralytica; Dementia Precox; Mental Disorders; etc.; Medicolegal Abstracts at end of letter M
INSECTICIDES, DDT: See DDT
spray, efficacy in aircraft, [Garnham] 140—ab
INSECTS: See also Bees; Flies; Lice; Mosquitoes
survive flight into lonosphere by rocket, 874—OS
INSEMINATION: See Impregnation
Prevention of: See Contraception
INSIGNIA: See also Emblems
of A. M. A. adopted in 1910, [Fishbein] ★763
INSTITUTE: See also Cancer; National Institute; Societies and Other Organizations at end of letter S
for Study of Rheumatic Fever at Northwestern U., 791
of Medicine of Chicago: See Chicago
of Rehabilitation, campaign to raise 2 million, 50
INSTITUTIONS: See Hospitals; Schools; Schools, Medical
INSTRUCTION: See Education; Education, Medical; Schools; University
INSTRUMENTS: See Apparatus; Medical Supplies
Sterilization of: See Sterilization, Bacterial
INSULAR Tissue (Islands of Langerhans): See Pancreas
INSULIN, discoverer, Dr. Best awarded honorary degree, Netherlands, 712
discoverer, liberty ship named for Dr. Banting, 1294
globin insulin with zinc, N.N.R., (Squibb) 543
Hyperinsulinism: See Pancreas, secretion
pharmacoradiographic agent, 420
resistance, extreme, [McGavack] 891—ab
shock therapy plus electroshock, in schizophrenia, [Polatin] 726—ab
test for intact nerve fibers after vagotomy, [Hollander] 1307—ab
Treatment: See Diabetes Mellitus
INSURANCE: See also Medicolegal Abstracts at end of letter M
A.M.A. resolution on freedom of choice of physician in 1917, [Fishbein] ★841
compulsory, dental benefits under, England, [Josselyn] 125—C
INSURANCE—Continued
fundamental requirements, 481—E; [Dickinson] ★483
group, as it affects physician, [Rees] ★613
Hospitalization: See Hospitals, expense insurance
Life: See also Metropolitan Life Insurance Co.
Life Insurance Medical Research Fund awards for research, 937
Medical Society Medical Service Plan: See Medical Service Plans
Old Age: See Social Security
sickness benefits, trade union plans for, [Dickinson] ★1285
sickness (compulsory), and the A. M. A., [Fishbein] (representative sent to Europe to study, 1913) ★770; (in 1916) ★837; (changing view, 1920-1924) ★923; (condemned) ★924
sickness, income raised for admission, Netherlands, 712
Sickness, National Health Service Act: Beveridge Plan: See National Health Service Act
sickness (nationwide), administration revives demand for, 184—OS; 556—OS
sickness, new fees for Dutch doctors, 1300
sickness, Wagner-Murray-Dingell Bill: See Wagner
social, A.M.A. Council on Health and Public Instruction committee report, [Fishbein] ★836; ★839; ★840; ★841; ★844; ★846; ★847; ★922
INTELLIGENCE tests, level of intelligence fluctuates with size of family, 961
INTER-AMERICAN: See also Latin America; Pan American; South America
Congress of Radiology (2nd), 639
Congress on Brucellosis (1st), 118; (proceedings) 798
INTERCOURSE, Sexual: See Coitus
INTERIM Commission: See World Health Organization
INTERN: See Interns and Internships
INTERNAL MEDICINE, California Society of, organized, 636
INTERNAL SECRETION, Glands of: See Endocrine Glands
INTERNATIONAL: See also United Nations; list of Societies at end of letter S
College of Surgeons purchases headquarters, 1025
Congress for Orthopedic Surgery and Traumatology, Sept. 1948, 1300
Congress of Military Medicine, Berne, 262; 1231
Congress on Legal Medicine, 564
epidemiologic reporting service by World Health Organization, 258
Health Congress, Puerto Rico, 1230
Medical Congress, 878
Medical Congress in 1887, [Fishbein] ★312; ★313; ★690
Society of Surgery, London, 639; 961
INTERNMENT Camps: See World War II, prisoners
INTERNS and INTERNSHIPS: See also Residents and Residencies
appointment, ★1082
approved by A. M. A., (additional list of) ★1078; (number) ★1081
Association of, 337
living quarters in Japan, 196
9-9-9 program, A.S.T.P., 874—OS
opportunities, statement by Dr. Johnson (Joint Committee report), 41
placement plan (uniform), 267
2 year, required at Cook County, 791
INTERVERTEBRAL Disk: See Spine
INTESTINES: See also Appendix; Cecum; Colon; Duodenum; Feces; Gastrointestinal Tract; Peritoneum; Rectum; etc.
bacteria, alteration of flora, 970
bacteria, urea to differentiate Proteus and paracolon cultures, [Christensen] 136—ab
cancer, adenomas in relation to, [Helwig] 1313—ab
Disease: See Appendicitis; Colitis; Diarrhea; Typhoid
diverticulosis cause of intestinovesical fistula, [Barnes & Hill] ★456
Fistula: See Fistula
Hernia: See Hernia
infections, streptomycin for [Pulaski] 571—ab
inflammation, regional enteritis in pregnancy, [Williams] 966—ab
Intussusception: See Intussusception
mucosa extract, enterogastrone in peptic ulcer, [Greengard] 1307—ab
obstruction, penicillin for, [Blain] 134—ab
Parasites: See Ancylostomiasis; Ascariasis
strangulation volvulus, early diagnosis; management, [Evans & Bigger] ★513
tumors, adenomas, relation to cancer, [Helwig] 1313—ab
tumors of dysenteric origin, [Silverman & Leslie] ★994
INTOCOSTRIN: See Curare
INTOXICATION: See Alcoholism
INTRAVENOUS Anesthesia: See Anesthesia, pentothal sodium
Clotting: See Phlebothrombosis
Injection: See Injections
INTUBATION: See Duodenal Tube; Endotracheal Tube
INTUSSUSCEPTION of appendix, [Milh] 208—ab
retrograde, [Thorek & Lorimer] ★21
INVESTIGATION, Investigators; See Research
INVESTMENTS, doctor reviews his portfolio, [Smith] ★27
IODINE, endemic goiter due to lack of? [Greenwald] 891—ab
radioactive, therapy in hyperthyroidism, [Hertz] 726—ab
IODIZED OIL, intrabronchial instillation, [Kooperstein] 499—ab
Intrauterine injection, venous intravasation after, [Bloomfield] 805—ab
IODIZED SALT: See Salt
ION TRANSFER, ionization measurements with bone chambers, [Stenstrom] 887—ab
IONOSPHERE, insects survive flight by rocket into, 874—OS
IOWA, State University of: See State University
IRISH (Henry E.) Lecture: See Lectures
IRON, harmful effects of prolonged use of ferrous sulfate and ferrous gluconate, 655
Nuxated Iron, 883—BI
use to avoid allergy to liver extract, [Sullivan & Broun] ★178
IRONS, ERNEST E., presidential address on focal infection, 111—E
IRRADIATION: See Radiation
IRRIGATION: See Bladder; Peritoneum; Stomach lavage
ISLANDS of Langerhans: See Pancreas
ISONIPECAINE: See Meperidine
ISOPROPYL ALCOHOL for sterilizing metal instruments, 734
ITALY, American medical books lacking in, 644
demerol in, [Musella] 198—C
ITCHING: See Eczema; Pruritus
IVY, A. C., A. M. A. Judicial Council on report on German atrocities, 35
IVY, Poison: See Rhus

J

J. A. M. A.: See American Medical Association
JACOBI, ABRAHAM, valedictory address, 1912, [Fishbein] ★767; ★768
JACOBI Fellowship: See Fellowship
JAPAN, at War: See World War II
contact dermatitis from Japanese rifles, [Hinman] 132—ab
food needs, survey, 559
406th medical general laboratory in Tokyo, 186
health conditions, report by Gen. MacArthur, 252
medical education reform in, 196
Population Policy Commission adopts program of eugenics, 185—OS
JAPANESE B Virus: See Encephalitis
River Fever: See Tsutsugamushi Disease
JASMINE Root: See Gelsemium
JAUNDICE, after penicillin treatment, [Hughes] 352—ab
complicates typhoid in child, [Sepulveda de Borquez] 1247—ab
Epidemic: See Liver inflammation
hemolytic (familial chronic) complications, [Aarseth] 968—ab
hepatocellular (primary), treatment, [Snell] ★1179
of newborn kernicterus in erythroblastosis fetalis, [Vaughan] 203—ab
spirochetal, Weil's disease, [Robertson] 502—ab
treatment, management of patient; surgical indications, [Snell] ★1175 (diet) ★1178
JAWS: See also Teeth
dislocation (recurrent), 74
phossy, extermination, 643
JAYNE'S Vermifuge, 883—BI
JEFFRIES Award: See Prizes
JEWS: See Palestine
JOBS: See Industrial Health
JOHNSON, VICTOR, appointment to Mayo Foundation, 527—OS
JOINT Committee for Coordination of Medical Activities: See American Medical Association Joint Committee
JOINTS: See also Arthritis; under names of specific joints as Knee; Shoulder; Wrist
Degenerative Disease: See Osteoarthritis
penicillin injected into, [Tucker] 892—ab
Surgery: See Arthroplasty
JONES, PHILIP MILLS, [Fishbein] (proposed Drug Bureau; cartoon) ★683; (proposed reference committee) ★688; (A. M. A. memorandum on death of, 1917) ★840
JOURNALS: See also Articles; Library; Newspapers
abstract, from England, Netherlands and the U. S., 480—E
abstract, series by Excerpta Medica, Inc., 416
American Journal of Tropical Medicine, editor resigns, 794
American Medical Journalist cartoons against A. M. A. Council, [Fishbein] ★681; ★683
Annals of Western Medicine and Surgery, new journal, 1227
Archives published by A. M. A.: See American Medical Association, journals (special)

JOURNALS—Continued
Archivos de Neuro-Psiquiatria, new journal, 1295
British Journal of Nutrition to replace Proceedings, 880
British Medical Bulletin, symposium on background to chemotherapy, 478—E
British Medical Journal (growth of, 1880), [Fishbein] ★236; ★237; (coal crisis affects publication in Feb. 1947) 698—E; 880
Cadernos Clentificos, 258
for general practitioners, urge A. M. A. to publish in 1912, [Fishbein] ★766
Hygeia: See American Medical Association
Indian Journal of Radiology, new journal, 416
Journal of the A. M. A.: See American Medical Association
Ladies Home Journal, iodized salt and goiter, 626—E
Lancet not published during coal crisis, 880
Medical Annals of District of Columbia, editor consults his readers, [Wiprud] 624
medical ethics and, P. Maxwell Foshay on, 1900, [Fishbein] ★534
medical, needed in Netherlands, [Taylor] 345—C; [Kouwer] 715—C; 878
medical (privately owned), enemies of A. M. A., [Fishbein] ★686
microfilm service of Army Medical Library, 789
New English Journal of Medicine, (editorial against William Brady, M.D.) 249—E; (editor consults his readers) [Wiprud] 624—ab; [Nye] 625—ab
New York Medical Record attacks on A. M. A., [Fishbein] ★685; ★686
Nutrition Bulletin, new journal, 495
Occupational Therapy and Rehabilitation, new sponsor, 257
of A. M. A.: See American Medical Association
of public health proposed to be published by A. M. A., 1912, [Fishbein] ★762; ★766
Ohio Historical Quarterly, [Forman] 625—ab
Ohio State Journal of Medicine, editor consults his readers, [Forman] 625—ab
Philippine Journal of Surgery, new journal, 1231
Postgraduate Medicine, new journal, 1025
Revista de Nutricion, 118
Science editor dies, W. L. Valentine, 1230
state, editorial condition and advertising, [Fishbein; Kosmak] 626—ab
state, history of, [Fishbein] ★690
Wisconsin Medical Journal 1947 blue book, 956
JUDD Lecture: See Lectures
JULY Fourth: See Fourth of July
JUNGLE rot causes false positive syphilis test, 73
JURISPRUDENCE, MEDICAL: See Medical Jurisprudence

K

KB, cancerolytic substance of Trypanosoma cruzi, 111—E; 122; [Gross] 800—C; [Klyuvea] 1038—ab
KAHN TEST for syphilis in healthy men, [Wolman] 128—ab
KALA-AZAR: See Leishmaniasis
KALSEKOM Tablets, 883—BI
KAPPA Sigma Fraternity: See Prizes
KEELEY Cure of alcoholism, [Fishbein] ★386; ★387
KEEN, W. W., campaign for animal experimentation, 1897, [Fishbein] ★170
presidential address in 1900, [Fishbein] ★534
KELLER, HELEN, British National Institute for Blind praises, 261
KELOID, hernia of anterior tibial muscle (repig), [McKeever] 214
KENYA Colony, immunizations for, 434
KERASIN, staining, histochemical method in Gaucher's disease, 496
KERATITIS (delayed) from mustard gas possible? 145
superficial punctate, human globulin for, 508
KERATOCONJUNCTIVITIS, epidemic, use of human globulin for, 508
KERNICTERUS in erythroblastosis fetalis, [Vaughan] 203—ab
KIDNEYS: See also Urinary System
decapsulation for anuria, [Reid] 503—ab
diagnosis, arteriography in, [Wagner] 965—ab
disease, in early syphilis, [Thomas] 888—ab
disease, lower nephron, [Lucke] 572—ab
excision for hypertension with unilateral renal disease, [Ratliff & others] ★296
extract, renin in cardiac failure, [Merrill] 424—ab
extract, renin in essential hypertension, [Taquini] 61—ab
Glomeruli: See Nephritis, glomerular
glycosuria, 899
Inflammation: See Nephritis
insufficiency, peritoneal irrigation in acute failure, [Fine] 426—ab; [Goodyear & Beard] ★1208
necrotizing papillitis, [Robbins] 1035—ab
osteodystrophy, [Norman & others] ★771

KIDNEYS—Continued
pathologic changes from streptomycin, [Musbett] 1242—ab
Pelvis: See Pyelography; Pyelonephritis
pressor substance in blood in hypertension, [Kreutzfeldt] 431—ab
regulation of acid-base balance; reabsorption and excretion of bicarbonate, 777—E
rupture (spontaneous), [Beard] 139—ab
Surgery: See Kidneys decapsulation; Kidneys, excision
tetraethyl, therapy of thromboangiitis obliterans injures (Council report), 693
tuberculosis, relation to primary tuberculosis, [Ustvedt] 1318—ab
tumors, hypernephpma (bilateral), [Senger] 1311—ab
KILGORE-Magnuson bill, planning for health, 180—E
KILLED in Action: See World War II, Heroes
KING, E. A., fraudulent salesman, 1230
KIRK, NORMAN T., honorary degree to, 789
KIRSCHNER electrocoagulation of gasserian ganglion, 577
KITCHEN, danger in, 1295
Utensils: See Cooking and Eating Utensils
hospital, danger from DDT to control flies in, 73
KLEBSIELLA granulomatis, urinary infection, streptomycin for, [Adcock & Plumb] ★579
pneumoniae (Friedlander's bacillus) meningitis, streptomycin for, [Tartakoff] 351—ab
KNEE, prostheses, internal control, 435
wounds (penetrating), management, [Hampton] 349—ab
KOBER Lecture: See Lectures
Medal: See Prizes
KOROMEX Cream and Applicator, N. N. R., (Holland-Rantos), 321
KRASHENINNIKOV, applied Besredka's theory in cancer treatment, 111—E; [Gross] 800—C
KRETSCHMER Lecture: See Lectures

L

LABELS, warnings on prescribed drugs, (Council discusses), 850
LABOR: See also Abortion; Cesarean Section; Obstetrics; Pregnancy; Puerperium
accelerating, new method with thiamine hydrochloride, Russia, 122
Anesthesia in: See Anesthesia
Complications: See Eclampsia
ergonovine and posterior pituitary injection compatible in same syringe? 1044
prolonged, especially postpartum hemorrhage, [Odell & others] ★735
prolonged, posterior pituitary injection in, [Reid]] 425—ab
South African Negro or Bantu as parturient, [Heyns] 1037—ab
vitamin K given routinely before delivery, 970
LABOR, MANUAL: See Industrial Health; Work
LABOR RELATIONS: See Industrial Health; Medicolegal Abstracts at end of letter M
LABOR UNIONS: See Industrial Trade Unions
LABORATORIES, Blood Group Reference, England, 566
clinical, at Rio Piedras, 1230
commercial, advertising of, [Fishbein] ★926
406th medical general, in Tokyo, 186
geriatrics research, N. Y., 116; 414
investigation in diagnosing virus infections, Chadwick lecture by S. P. Bedson, 1299
Rh Factor, set up, Washington, D. C., 184—OS
specialists, conference, 1018
Technician: See also Technologists, medical
technician, A. M. A. adopts new name; medical technologist, ★1150
to make vaccines, Puerto Rico, 336
LACQUER, contact dermatitis from Japanese rifles, [Hinman] 132—ab
LACTATION: See Milk, human
LACTOBACILLUS, alteration of intestinal flora, 970
Casei Factor (synthetic): See Acid, folic
LACTOFLAVIN: See Riboflavin
LACTOSE with fats, nutritive value, [Ershoff] 1304—ab
LADIES HOME JOURNAL: See Journals
LAENNEC'S Cirrhosis: See Liver, cirrhosis
LAMBERT, ALEXANDER, A. M. A. Judicial Council report on social insurance, [Fishbein] ★836
LAMBLIASIS: See Giardiasis
LAMINITIS (founder) in horses, bear resemblance to gout? 434
LANATOSIDE C for auricular flutter, [Tandowsky] 424—ab
LANCET: See Journals
LANGERHANS, Islands of: See Pancreas
LANGUAGE: See English; Terminology
LARYNGOLOGY: See Otolaryngology; Otorhinolaryngology
LARYNGOTRACHEOBRONCHITIS, [Morgan] 1242—ab
LARYNX: See also Voice
excision, organization of those who have undergone; where obtain artificial voice aids? 146
LASKER AWARD: See Prizes
LATIN-AMERICA: See also Inter-American; Pan American; South America

LATIN AMERICA—Continued
gastroenterologists and nutritionists meet, 343
health activities in, 118
medical news from, 258; 714; 882
LAVAGE: See Irrigation (cross reference); Stomach
LAW: See Attorneys
in relation to Medicine: See Medical Jurisprudence
LAWS AND LEGISLATION, A. M. A. Bureau of: See American Medical Association
A. M. A. Committee on, 1905-1909, [Fishbein] ★681
bill to end "fly by night" training schools for practical nurses, 482—OS
Carlson (A. J.) recommends scientist initiate counter antivivisection bills, 51
federal and state, weekly summary, 185; 251; 328; 406; 484; 557; 632; 700; 785; 872; 948; 1017; 1161; 1219; 1286
federal, what's ahead for 80th Congress? [Miller] 555—ab
Food, Drug and Cosmetic Act: See Food
Fulbright-Taft Bill: See Taft
G. I. Bill of Rights: See G. I. Bill of Rights
Harrison Narcotic Law: See Harrison
Hill-Burton Act: See Hill-Burton Act
law authorizing practice of naturopathy repealed, Tenn., 415
Lemke Antivivisection Bill: See Lemke
state, and state medical society, [Barker] 549—ab
Taft-Smith-Ball-Donnell Medical Care Bill: See Taft
U. S. Army Medical Department, proposed legislation, 873—OS
Violation of: See Medical Jurisprudence; Medicolegal Abstracts at end of letter M
Wagner-Murray-Dingell Bill: See Wagner
water pollution control bill, 1219—OS
LAWSUITS: See Medical Jurisprudence
LAWYERS: See Attorneys
LAXATIVES: See Cathartics
LEAD poisoning, from bread, 644
tetraethyl, poisoning, [Cassells] 352—ab
LEAGUE of Nations: See United Nations
LEBEDENKO, VLADIMIR V., death, 52
LECTURES: See also under Book Notices at end of letter B
Alpha Omega Alpha, 563
Bacon, 1292
Barnard Hospital, [Warren] ★462
Bigg (Herman M.) Memorial, 793
Boston City Hospital, 413
Chadwick: diagnosis of virus infections, 1299
Crane Memorial, 792
Cutter, 1023
Davis (D. J.), 954
De Lamar, 876
Dock (George), 791
Eastman Memorial, 1164
Flexner, 415
Gifford (Sanford R.) Memorial, 115
Guerriero (Charles P.) Memorial, 877
Harvey, (4th) 116; (5th) 793
Hektoen, (Ludvig), 189; 561
Irish (Henry E.) Lectureship established, 791
Judd (E. Starr), 792
Kober, (George Martin), 1015—OS; 1159—OS
Kretschmer (Edwin R.) Memorial (6th), 875
McArthur (Lewis Linn), 561
Maimonides, 256
Martland (Harrison S.), 1164
Miller (Adam M.), 1024
Phi Delta Epsilon, 1293
Proctor (Francis I.) (1st), 255
Rothschild, 414
Smith (Reginald Knight), 560
Sommer (Ernest A.) Memorial, 955
Surman (Arnold C.) Memorial, 956
U. S. Naval Medical Center series of great lecturers, Bethesda, 488
Wilder (William Hamlin) Memorial, 875
Zeit (Frederick Robert) Memorial, 1227
LEG: See Legs
LEGAL MEDICINE: See Laws and Legislation; Medical Jurisprudence; Medicolegal Abstracts at end of letter M
A. M. A. Bureau of: See American Medical Association
LEGION of Merit: See World War II, Heroes
LEGISLATION: See Laws and Legislation
LEGS: See also Extremities; Femur; Foot; Knee
Amputation of: See Amputation
arteriosclerotic, treatment, 1320
Artificial: See Limbs, artificial
blood pressure in, [Stewart] 424—ab
crossing, causes peroneal palsy, [Nagler & Rangell] ★755
trauma, refrigeration in, [Pernworth] 1308—ab
Ulcers: See Ulcers; Varicose Veins
LEIOMYOMA, esophageal; successful resection, [Schafer & Kittle] ★1202
LEISHMANIASIS, cutaneous, culture method in, [Dostrovsky] 269—ab
syphilis serodiagnostic false positive reactions in, 73
treatment, antimoniate of N-methyl glucamine, also diamidine, 429

133
947

LEMKE Antivivisection Bill, 184—OS; 327—OS; 631—OS; 948—OS
LEMON juice dissolves tooth substance, 1218—E
LENIN, NIKOLAI, conservation of his body, 1235
LENS, CRYSTALLINE, Opacity: See Cataract
LENSES, Contact: See Glasses
LEPROSY, treatment, diasone, [Muir] 967—ab
treatment, promin, [Wharton] 967—ab
treatment, promin and promizole, 46—OS
LEPTOSPIROSIS: See also Jaundice, spirochetal
canicola fever, [Rosenbaum] 571—ab
canicola, penicillin for [Baber] 140—ab
LEPTOTRICHOSIS, Parinaud's conjunctivitis, 357
LERICHE, Professor, personal, 960
LETTERS: See Mail
LEUKEMIA, mortality from, 547—E
priapism in, dicumarol contraindicated, 73
LEUKOCYTES: See also Eosinophilia; Mononucleosis, Infectious
Count: See also Agranulocytosis, Acute; Leukemia
count in multiple myeloma, [Bayrd & Heck] ★151
formula in liver cirrhoses, [de Graciansky] 503—ab
LEUKOTOMY: See Brain surgery
LEVY Foundation: See Foundations
LIBBY'S strained products for infants, 937
LIBEL suits against A.M.A., 1917, [Fishbein] ★836; ★840; ★843
LIBIDO, vitamin B complex affect? 1253
LIBRARIANS: See Library; Medical Record Librarians
LIBRARY: See also Books; Journals; Newspapers
Klebs, of medical history to Yale, 334
Netherlands, medical literature needed for, [Taylor] 345—C; [Kouwer] 715—C; 878
Surgeon General's, INDEX CATALOGUE of, [Fishbein] ★103
Tulane University, Rudolph Matas gives 50 year files to, 561
U. S. Army Medical, 186: (in 1885) [Fishbein] ★311; (new director: Col. McNinch) 329; (microfilm service available to physicians) 789; (Association of Honorary Consultants, Inc.) 1018; (acquires CHINESE GOLDEN MIRROR OF MEDICINE) 1018
war devastated, book center for, 878
LICE, Infestation: See Pediculosis
louse borne relapsing fever, penicillin for [Ingraham] 207—ab
louse borne typhus, ear symptoms, [Merei] 1318—ab
LICENSURE: See also State Board
A.M.A. Annual Congress on (program) 34—E; 59: (proceedings) 856—OS
diploma mill scandal, 1924, [Fishbein] ★932; ★933
Indiana Supreme Court upholds revocation of license, 413
Kern County Hospital investigation, Calif., 1291
model hospital licensing law, 946—OS
of returning medical officers, (Joint Committee report), 43
temporary permits to practice, Fla., 1022
LICHEN (botanical), Ramalina reticulata, antibiotic from [Marshak] 1245—ab
LICHEN (dermatologic) planus (atypical), [Wilson] 209—ab
LIDS: See Eyelids
LIECHTI, ADOLF, death, 52
LIFE: See also Death
Duration: See Old Age
Insurance: See Insurance; Metropolitan Life Insurance Co.
"Long Life and a Merry One," CBS radio presentation reviewed, 1161—OS
LIGATURE: See Suture
LIGHT, sensitivity, to, benadryl for, [Tyson] 137—ab
LIMBS: See Extremities
Phantom: See Amputation
LIMBS, ARTIFICIAL: See also Amputation
best artificial leg for midthigh amputation? 656
internal control knee prostheses, 435
manufacture, [Ritter] 1237—C
manufacturers, convictions against reversed by court, 405—OS
model of new hand, 408
production of more efficient, 482—OS
suction sockets for, 703
LINN, A. E., death, 567
LIPOIDOSES, Niemann-Pick disease within group of, [Pfandler] 1247—ab
LIPOMA of cauda equina, [Furtado] 208—ab
of corpus callosum, [Amyot] 502—ab
LIQUOR, Alcoholic: See Alcohol
LITERARY Guild: See Physicians avocations
LITERATURE: See Articles; Books; Journals; Library; Newspapers; Terminology; Writing
LITHIASIS: See Calculi (cross reference)
LITHIUM antimony thiomalate treatment in filariasis, [Brown] 268—ab
antimony thiomalate treatment in tuberculosis, [Brown] 268—ab
LIVER: See also Bile Ducts; Biliary Tract
abscess, emetine treatment in pyogenic infections, [Melchlor] 503—ab
LIVER—Continued
abscess, pyogenic (multiple), penicillin cures, [Michel & Wirth] ★395
amebiasis complications 496
amebic hepatitis, pleurisy from, (Carruthers] 1246—ab
atrophy (acute yellow), 1156—E
biopsy (needle) [Davis] 129—ab
cirrhosis (ascitic), transfuse ascitic liquid in, [Acevedo Olvera] 1317—ab
cirrhosis, blood bilirubin to differentiate from peptic ulcer, [Navarro] 351—ab
cirrhosis, intravenous liver extract therapy, [Labby & others] ★1181
cirrhosis (Laennec's), dietary treatment, [Patek] 427—ab
cirrhosis, leukocyte formula in [de Graciansky] 503—ab
damage, sucrose tolerance tests, [O'Brien & Higgins] 197—E
Disease: See also Jaundice
disease, dietetic factors, [Witts] 1315—ab
disease, methylxanthines effect on, prothrombin activity [Rieben] 69—ab
dysfunction, chronic subclinical impairment, early diagnosis; treatment, [Mateer & others] ★909
Extract: See Liver preparations
function, glucuronate excretion test [Snapper] 424—ab
function test, colloidal gold, Borowskaja method, 734
function tests, evaluated, [Mateer & others] ★909
function tests in intravenous liver extract therapy of cirrhosis, [Labby & others] ★1184
function tests in obstructive and hepatocellular jaundice, [Snell] ★1176
glycogen disease (familial), [Abramson] 570—ab
hypertrophy, hepatomegaly and portal obstruction in diabetic child, 279
inflammation complicating typhoid in child, [Sepulveda de Borquez] 1247—ab
inflammation (epidemic), galactose tolerance in [Schneiderbaur] 1172—ab
inflammation (infectious), [Moloney] 726—ab
inflammation (infectious), blood proteins in, [Armas-Cruz] 1247—ab; [Martin] 1315—ab
inflammation (infectious), etiology [Pendl] 967—ab
inflammation (infectious), fat in diet during recovery, [Hoagland] 490—ab
inflammation (infectious), immunity in, [Havens] 501—ab
inflammation (infectious), laboratory aids in, [Neefe] 890—ab
inflammation (infectious) may lead to acute yellow atrophy, 1157—E
inflammation (infectious), neurologic manifestations [Weinstein] 887—ab
inflammation, spread of poliomyelitis and, in Egypt [Van Rooyen] 428—ab
injury, prevention and treatment, methionine in (Council report), 107
Necrosis: See Liver atrophy (acute yellow)
pathologic changes from streptomycin, [Mushett] 1242—ab
preparations, allergy to extract, [Sullivan & Broun] ★178
preparations, extract in probable gastrointestinal lesion, 278
preparations, extract intravenously in cirrhosis [Labby & others] ★1181
Riedel's lobe [Gloyne] 426—ab
LIVESTOCK: See Animals
LIVING: See Life
Quarters: See Home; Housing
LOA LOA: See Filariasis
LOANS, Students: See Students, Medical
LOBECTOMY: See Lungs surgery
LOBOTOMY: See Brain surgery
LOCKJAW: See Tetanus
LOCOMOTOR Ataxia: See Tabes Dorsalis
LOEFFLER'S syndrome, 325—E; 776—E
LOEWI, humoral transmission of vagal and accelerator effects, 761—ab
LONGEVITY: See Old Age; Physicians, veteran
LOST Chord Society, organization of laryngectomized patients, 146
LOUISIANA Physicians Service, Inc., 46—OS; (seal of acceptance to) 112—OS
LOUSE: See Lice
LUCITE, use in extrapleural pneumonolysis, [McCain] 1312—ab
LUMBAR Puncture: See Spinal Puncture
LUMBOSACRAL Region: See Pilonidal Sinus
LUMINAL: See Phenobarbital
LUNGS: See also Bronchus; Pleura; Respiratory System
acariasis or tropical eosinophilia, [Hall] 967—ab
amyloidosis (primary) [Dirkse] 499—ab
asbestos and aluminum effect on, in rabbits [King] 208—ab
calcification (disseminated), [High] 1245—ab
cancer (apical) and Pancoast tumor of superior pulmonary sulcus, [Wicht] 254—ab
cancer (bronchiogenic) [Lindskog] 132—ab
Collapse: See also Pneumothorax; Pneumothorax, Artificial; Tuberculosis of Lung, artificial pneumothorax in
LUNGS—Continued
collapse, atelectasis complicating lobectomy, [Gray] 651—ab
collapse, atelectasis in upper urinary tract operations [Faulconer] 647—ab
Disease: See also Pneumonoconiosis; and other subheads under lungs
disease, statistical results of screening process, [Kollbrunner] 967—ab
edema, treatment with concentrated plasma, [Cleland] 352—ab
Embolism of Pulmonary Arteries: See Embolism, pulmonary
Hemorrhage: See Hemoptysis
Hyperventilation: See Respiration
Infection: See Influenza; Pneumonia; Tuberculosis of Lung
injuries, nonpenetrating, pneumonia after, penicillin or sulfadiazine, atropine and papverine to prevent [Phillips] ★161
lesions in skeletal tuberculosis, [Mann] 502—ab
pressure (intravascular), susceptibility to tuberculosis depends on, [Röder] 1237—C
roentgen study in Q fever, [Irons & Hooper] ★817
secretion (accumulated), endotracheal intubation for, [Foregger] ★1200
Superior Pulmonary Sulcus Tumor: See Thorax tumors
surgery, lobectomy and pneumonectomy in tuberculosis, [Sweet] 1310—ab
surgery, lobectomy, atelectasis complicating, [Gray] 651—ab
surgery, lobectomy brings low mortality, 1284—E
surgery, pneumonolysis (extrapleural), use of lucite, [McCain] 1312—ab
surgery, pneumonolysis, results, [Branday] 888—ab
surgery, resection, pneumonectomy, lobectomy in bronchial adenoma, [Tricerri] 895—ab
thresher's, [Tornell] 504—ab
transitory infiltration with eosinophilia (Loeffler's syndrome), 325—E; 776—E
Tuberculosis of: See Tuberculosis of Lung
Ventilation: See Respiration
LUPUS erythematosus, treatment: causes, 213
Vulgaris: See Tuberculosis luposa
LYDSTON, G. FRANK, battle with A. M. A. [Fishbein] ★764; ★769; ★843
LYMPHATIC SYSTEM: See also Mononucleosis, Infectious
diagnostic value of preauricular adenopathy, [Thygeson] ★437
LYMPHOCYTES: See Choriomeningitis
LYMPHOGRANULOMA Benignum: See Sarcoidosis
LYMPHOGRANULOMATOSIS: See Hodgkin's Disease
LYMPHOID TISSUE: See Nasopharynx

M

MBP (brucella antigen), Castaneda vaccine for undulant fever, 656
McARTHUR, DOUGLAS, reports on health conditions in Japan, 252
McARTHUR Lecture: See Lectures
MACATEE, HENRY C., A. M. A. stand against insurance legislation explained by, 482
McCLARAN, JAMES W., bronze plaque unveiled, 637
McCORMACK, J. N., A. M. A. organizer, [Fishbein] (1901) ★537; (1907) ★682; ★683; ★689; (death, 1922) ★928
McKINLEY, WILLIAM, at A. M. A. semicentennial meeting, 1897, [Fishbein] ★470
death, [Fishbein] ★607
McMURTRY, L. S., tribute to A. M. A. Board of Trustees, [Fishbein] ★684
McNINCH, J. S., new director of Army Medical Library, 329
MACU Brand Papaya Concentrate, 264—BI
MADAME, Trade names beginning with "Madame": See under surname
MAGAZINES: See Periodicals
MAGNESIUM hydroxide treatment of peptic ulcer, [Jankelson] 1240—ab
Silicate: See Talc
MAGUIRE, ALEXANDER, death of, extermination of "phossy jaw," 643
MAICO Atomeer hearing aid, 542
MAIL, soldiers' Christmas, lost at sea, 486
MAIMONIDES Lecture: See Lectures
MALARIA, control activities, USPHS annual report, 702
falciparum acute, pathology, [Spitz] 573—ab
hemoglobinuria (blackwater fever) in, transfusion for, [Jullard] 729—ab
immunity to vivax, [Reed] 135—ab
mortality and morbidity, [Faust] 201—ab
relapses, reduction, [Winckel] 431—ab
syphilis, false positive tests in, 73; [Rein & Kent] ★1001
therapeutic, neurosyphilis on decline 25 years after beginning of, 482—OS
therapeutic, plus penicillin in neurosyphilis, [Rose & Solomon] ★8
transmission by transfusion; danger, [Coggeshall] 1238—C
treatment, melarsen oxide, [Payne] 893—ab

V 19

MALARIA—Continued
treatment, quinacrine concentrations in plasma, [Becker] 202—ab
treatment, quinacrine hydrochloride, dermatosis from, [Peterkin] 727—ab
treatment, quinacrine suppression, individual failures, [Bang] 132—ab
treatment, quinine, A. M. A. anticipated need for, in 1870, [Fishbein] ★101
treatment, quinine and plasmochin combined for vivax type, [Most] 570—ab
MALE: See Spermatozoa
Characteristics in Women: See Virilism
Hormones: See Androgens
Impotence: See Impotence
Sterility: See Sterility
MALFORMATIONS: See Abnormalities
MALIGNANCIES: See Cancer; Sarcoma (cross reference); Tumors, malignant
MALLEOMYCES mallei, human glanders, 622—E
MALNUTRITION: See Nutrition deficiency
MALPRACTICE: See Medicolegal Abstracts at end of letter M
MALTA FEVER: See Brucellosis
MAMMARY: See Breast
MANDELIC Acid: See Acid
MANDIBLE: See Jaws
MANNITOL hexanitrate, N.N.R., (Smith-Dorsey) 179
hexanitrate for hypertension, 1042
MAPHARSEN: See Oxophenarsine
MAPS, medical service areas in U. S., 1011—E; [Dickinson] ★1014
"MARCH of Dimes": See Poliomyelitis
MARCHETTI, A. A., appointment at Georgetown, 948
MARIE-Strumpell Spondylitis: See Spine arthritis
MARRIAGE: See also Coitus; Contraception; Pregnancy; Medicolegal Abstracts at end of letter M
contraindicated in progressive muscular dystrophy? 212
cretinism and, 898
of first cousins advisable? 1320
premarital blood test regulations amended, Calif., 189
MARROW: See Bone Marrow
MARSHALL'S (Dr.) Scalp Medications, 568—BI
MARTLAND Lecture: See Lectures
MARTYRS: See also Heroes
poliomyelitis virus infection fatal in laboratory worker, [Wenner] 1303—ab
Ricketts (Howard Taylor), death in 1910, [Fishbein] ★764
MARYLAND, medical care in, [Riley] 132: ★326, 12, '40
MASCULINITY: See Virilism
MASTITIS: See Breast inflammation
MASTOIDITIS, treatment, penicillin, 420
MATERNITY: See also Families; Pregnancy
leave advocated for federal worker, 185—OS
mortality, continuous caudal anesthesia cause of, [McCormick] 801—C
mortality in prolonged labor, [Odell & others] ★735
MATHEWS, GRADY, Hoxsey—cancer charlatan, 774—E; (correction) 957
MAYO, CHARLES W., appointment, 113
MAYO, WILLIAM J., address of A. M. A. President, 1907, [Fishbein] ★687
MAYO Foundation: See Foundations
MEALS: See Restaurants
MEASLES, German: See Rubella
eruption, effects of antipyretic drugs on, 508
sharp increase, Mass., 637
MEASURES: See Weights and Measures
MEAT: See also Bacon; Trichinosis
Q fever in U. S., [Topping & others] ★813; [Irons & Hooper] ★815; [Irons & others] ★819; [Cox & others] ★820
question of best animal feeds effect on, 775—E
MECHOLYL bromide, toxicity, used as stimulant to smooth muscle of colon, 655
treatment of myasthenia gravis, 1252
MEDALS: See Prizes
for War Service: See World War II, Heroes
MEDIASTINUM, cysts and tumors, [Eerland] 431—ab
MEDICAL ACTIVITIES, Joint Committee for Coordination of: See American Medical Association Joint Committee
MEDICAL AID to China, American Bureau for, 709
MEDICAL AND SURGICAL RELIEF COMMITTEE, medical supplies for war needy, 1025
MEDICAL ANNALS: See Journals
MEDICAL ARTICLES: See Articles; Journals
MEDICAL ASSOCIATION: See American Medical Association; Societies, Medical; list of societies at end of letter S
MEDICAL AWARDS: See Prizes
MEDICAL BOOKS: See Books; Library; Book Notices at end of letter B
MEDICAL CARE: See Medical Service
MEDICAL CENTER: See also Health center; Hospitals, center
El Paso, 491
medical science center in Rome, 1231
New York University-Bellevue, 256; 1024
Northwestern University, 1292
predicted, Washington, D. C. 699—OS
MEDICAL CENTER—Continued
U. S. Naval, (lectures at) 488; (lecture by P. R. Hawley) 703; (discusses medical aspects of atomic warfare) 1225
University of Colorado, 1291
MEDICAL CLINIC: See Clinics
MEDICAL COLLEGE: See Schools, Medical; University
MEDICAL CONGRESS: See Congress
MEDICAL CORPS: See Army, U. S.; Navy, U. S.; Veterans Administration; World War II
MEDICAL DAYS of Brussels, 263
MEDICAL DEPARTMENT: See Army, U. S.
MEDICAL DIATHERMY: See Diathermy
MEDICAL DIRECTORY: See American Medical Directory
MEDICAL ECONOMICS: See Economics, Medical
MEDICAL EDITORS, Annual Conference of: See American Medical Association, Annual Conference
MEDICAL EDUCATION: See Education, Medical
MEDICAL EQUIPMENT: See Medical Supplies
MEDICAL ETHICS: See Ethics, Medical
MEDICAL EXAMINATION: See Physical Examination
MEDICAL EXAMINERS: See Coroners
MEDICAL FEES: See Fees
MEDICAL FREEDOM, National League of, [Fishbein] ★761
MEDICAL GROUPS: See Medicine, group practice
MEDICAL HISTORY: See Medicine, history
MEDICAL INSTITUTE: See Institute
MEDICAL JOURNALS: See Journals
MEDICAL JURISPRUDENCE: See also Evidence; Laws and Legislation; Medicolegal Abstracts at end of letter M
evaluating loss of hearing in medicolegal cases, (Council report) ★396
Indiana Supreme Court upholds license revocation, 413
International Congress on Legal Medicine, 564
Ohio Supreme Court upholds conviction on abortion charge, 491
symposium on medicolegal problems, Chicago, 334; 636
MEDICAL LECTURES: See Lectures
MEDICAL LEGISLATION: See Laws and Legislation
MEDICAL LIBRARY: See Library
MEDICAL LICENSURE: See Licensure
MEDICAL LITERATURE: See Literature (cross reference)
MEDICAL MAGAZINES: See Journals
MEDICAL MEETINGS: See Societies, Medical; list of Societies at end of letter S
MEDICAL MOTION PICTURE Reviews: See Motion Pictures, Medical (Reviews)
MEDICAL OFFICERS: See Army, U. S.; Navy, U. S.; World War II
Returning: See Veterans, physician
MEDICAL PERIODICALS: See Journals
MEDICAL PLANS: See Medical Service Plans
MEDICAL PRACTICE: See Medicine, practice; Physicians
MEDICAL PRACTICE ACTS: See Licensure; Medicolegal Abstracts at end of letter M
MEDICAL PRACTITIONERS UNION and National Health Service, England, 495
MEDICAL PREPAREDNESS: See World War II
MEDICAL PRIZES: See Prizes
MEDICAL PROFESSION: See Medicine, profession of; Physicians; Surgeons
MEDICAL RECORD: See Journals
MEDICAL RECORD LIBRARIANS, schools for, approved by A. M. A., ★1147; 1157—E
shortage; grants for extension course, 622—E; 639
statistics on, in all hospitals, ★1077
MEDICAL RESEARCH: See also Research Council, (difficulty of finding cure for common cold) 419; (clinical tests with streptomycin) 1234
MEDICAL SCHOOLS: See Schools, Medical
MEDICAL SCIENCE: See Medicine; Research; Science
MEDICAL SERVICE: See also Consultants; Health center; Health service; Hospitals; Insurance, sickness; Medical Center; Medicine, group practice; Medicolegal Abstracts at end of letter M
A. M. A. Council on: See American Medical Association
A. M. A. Reference Committee, report, 38
areas in U. S., apply principles of retail trading, 1011—E; [Dickinson] ★1014
doctor makes mercy flights piloting his own plane, 788—OS
Emergency: See Emergency
for Armed Forces: See World War II
for Children: See Health services
for low income groups under Taft-Smith-Ball-Donnell Bill, 869—OS
for lower income groups, committee report, [Cooper] 865—ab
for natives, Buenos Aires, 882
for Veterans: See Hospitals, veterans; Veterans, medical care
MEDICAL SERVICE—Continued
free, from 1950, Sweden, 420
Industrial: See Industrial Health
maladjustment, locating doctor at every crossroad not the solution, [Shoulders] 866—ab
National Conference on, 337
Plans: See Medical Service Plans *following*
Rural: See Rural Communities
Supply of Physicians for: See Physicians, location; Physicians, supply
Taft-Smith-Ball-Donnell Bill: See Taft Wagner-Murray-Dingell Bill: See Wagner
MEDICAL SERVICE PLANS: See also Hospitals, expense insurance; Medicolegal Abstracts at end of letter M
A. M. A. Council on Medical Service, (report) 35; (seal of acceptance awarded) 112—OS
film on prepayment (Reference Committee report), 36
fundamental requirements of insurance applied to, [Dickinson] 481—E; ★483
rural enrolment experience, Kansas City, Mo., [Helsby] 407—ab; [Mertz] 782—ab
voluntary prepayment, committee report, [Doughty] 862—ab
MEDICAL SOCIETY: See Societies, Medical; list of societies at end of letter S
MEDICAL STUDENTS: See Students, Medical
MEDICAL SUPPLIES: See also Apparatus; Cast; Dressings; Drugs; Suture
for war needy, 1025
surplus drugs, sale of, 951
surplus medical, dental and hospital supplies, subcommittee report, 941—OS
surplus plasma distributed by American Red Cross, 482—OS
surplus property (Joint Committee report), 41
surplus, sale, 703; 1162; 1225
surplus, sale of portable roentgen apparatus, 559
surplus surgical sutures, sale 114
surplus transfusion sets, sale of, 951
MEDICAL TECHNICIANS; Technologists: See Technologists
MEDICAL TERMINOLOGY: See Terminology
MEDICAL TESTIMONY: See Evidence
MEDICAL VETERANS: See Veterans, physician
MEDICAL WOMEN: See Physicians, women
MEDICAL WRITING: See Literature (cross reference)
MEDICALLY HANDICAPPED: See Disability; Handicapped
MEDICATION: See Drugs; Self-Medication
MEDICINE: See also Education, Medical; Medical Service; Physicians; Surgery
Academy of: See Academy
Advances in: See Medicine, progress
Annals of Western Medicine and Surgery, 1227
Anglo-French medical cooperation, West Africa, 195
Aviation: See Aviation
Congress of: See Congress
Cults: See Chiropractors; Cults; Naturopathy; Osteopaths
Fellowships: See Fellowships
Forensic: See Medical Jurisprudence
Foundations aiding: See Foundations
group practice, and A. M. A. in 1922, [Fishbein] ★927; ★928
group practice, medical groups in U. S., 1946, [Dickinson] ★1222
history, A. M. A. resolutions on establishing A. M. A. Council on, 40
history, autobiography of Cardano, 749—ab
history, Chinese Golden Mirror of Medicine (1749) at Army Medical Library, 1018
history, first operation for gallstones by Dr. Bobbs, 1905, [Fishbein] ★683
history, Klebs Library of, Yale receives, 334
history of Ohio, in Ohio Historical Quarterly, [Forman] 625—ab
history of, Puerto Rico, 1230
Industrial: See Industrial Health
Institute of: See Institute
Internal: See Internal Medicine
Law in relationship to: See Medical Jurisprudence
Lectures on: See Lectures
Legal: See Legal Medicine (cross reference)
"Medicine Serves America," electrical transcriptions by A. M. A. Bureau, 324—E; 326
Military: See Military Medicine; World War II
nursing and, a joint enterprise, 20—ab
Organized: See American Medical Association; Societies, Medical
Physical: See Physical Medicine
Practice: See Licensure; Medical Service; Medicine, group practice; Physicians; Specialties
practice, euphemisms and equivalents in, 183—E
practice, Indiana Board of General Practice of Medicine, Inc., by-laws, 43; 942—OS
Practice, Opportunities for: See Physicians, positions open
Preventive: See Preventive Medicine
Prizes: See Prizes
Profession of: See also Physicians; Specialists; Surgeons; etc.

MEDICINE—Continued
profession of, and public relations, [Swart] 554—ab
profession of, ethical responsibilities, in Germany; brutalities in American psychiatric hospitals, [Wertham] 645—C
profession of, USPHS to survey, 1159—OS; [Dickinson] ★1222
progress and research, 400—E
Psychosomatic: See Psychosomatic Medicine
Research in: See Research
Royal Society of: See Royal Society
Rural: See Rural Communities
Scholarships: See Scholarships
Socialized: See Insurance, sickness; Insurance, social; Medicine, state
Socialized, National Health Service (White Paper; Beveridge Scheme): See National Health Service Act
Socialized, Wagner-Murray-Dingell Bill: See Wagner
Societies: See Societies, Medical
Specialization: See Specialization; Specialties
state, A. M. A. definition, [Fishbein] ★925; ★928
Tropical: See Tropical Medicine
Women in: See Nurses; Physicians, women
MEDICINE AND THE WAR: See World War II
MEDICINES: See Drugs; Nostrums; Proprietaries
MEDICOLEGAL: See Legal Medicine (cross reference); Medicolegal Abstracts at end of letter M
MEDREX Ointment and Soap, 422—BI
MEDULLA SPINALIS: See Spinal Cord
MEEK Fund: See Foundations
MEETINGS: See Societies, Medical; list of Societies and organizations at end of letter S
MEGACOLON: See Colon
MELANCHOLIA: See also Mental Depression
treatment, prefrontal leukotomy in women, [Parker], 274—ab
MELANOPHORE reaction in diagnosis of pregnancy, [de Bourgraaf] 730—ab
MELANOSIS, congenital papillary, 714
MELARSEN oxide in malaria, [Payne] 893—ab
oxide in tropical disease, [Payne] 893—ab
MEMORIAL to Physicians: See Physicians
MEN: See Male (cross references)
in Service: See Veterans; World War II
MENADIONE, solution (in oil), N.N.R., (Miller; Vale), 937
MENCKELL, BROOKS: warning of impostor, 492
MENIERE'S Syndrome: See Vertigo, aural
MENINGES, cerebellar subdural hydroma, [Grant] 889—ab
Hernia of: See Meningocele
MENINGITIS: See also Arachnoiditis; Meningoencephalitis
Benign lymphocytic: See Choriomeningitis
diagnosis, symptomatology, [Vujic] 895—ab
Friedländer's bacillus, streptomycin for, [Tartakoff] 351—ab
influenzal, outcome vs. bacterial type, [Zinnemann] 894—ab
influenzal, streptomycin for, [Hoyne] 721—ab
pneumococcic, sulfonamide plus penicillin in, [Ross] 892—ab
MENINGOCELE, hinterthoracic, [Cabello Campos] 730—ab
MENINGOCOCCEMIA, sudden and unexpected deaths of young soldiers, 325—E [Moritz] 721—ab
MENINGOCOCCUS Septicemia: See Meningococcemia
MENINGOENCEPHALITIS after vaccination for zoster ophthalmicus, [Madonick] 133—ab
Syphilitic: See Dementia Paralytica
MENINGER Foundation: See Foundations
MENOPAUSE, delayed, and uterine myoma, [Crossen] ★597
pathologic findings in genital bleeding 2 or more years after, [Cheek] 425—ab
vitamin B complex affect? 1253
MENORRHAGIA: See Menstruation disorders
MENSTRUATION, Cessation of: See Menopause
Disorders: See also Dysmenorrhea
disorders, androgens in functional uterine bleeding, 1253
disorders, control menorrhagia by testosterone and progesterone, [Greenblatt] 723—ab
epilepsy during, [Burnett] 1037—ab
migraine associated with, 812
premenstrual bleeding, 214
Story of (motion picture review), 1033
vicarious, 811
MENSURATION: See Weights and Measures
MENTAL DEPRESSION: See also Melancholia
treatment, surgical [Van Wagenen] 273—ab
MENTAL DISORDERS: See also Alcoholism; Dementia Paralytica; Dementia Precox; Psychoses
cerebral dysrhythmia and psychopathic personalities, [Simon] 721—ab
diagnosis, grammar-rhetoric indicator, [Mayer] 725—ab
diagnosis, methedrine in, [Simon] 724—ab
Hospitalization in: See Hospitals, psychiatric; Hospitals, state
porphyria, [Schneck] 202—ab
MENTAL DISORDERS—Continued,
psychiatric sense and nonsense, [Burlingame] ★971
research, USPHS funds for, 790
treatment, bilateral frontal lobe leukotomy, [McKenzie] 134—ab
treatment, electric sleep (shock), [Holbrook] 65—ab
treatment, new program, Calif., 954
treatment, prefrontal leukotomy in 100 women, [Parker] 274—ab
treatment, prefrontal leukotomy, results, England, 1234
treatment, restraint of insane, 1878, [Fishbein] ★177
treatment, shock treatments with curare (intocostrin), [Cohen] 503—ab
MENTAL EFFICIENCY: See Intelligence
MENTAL HEALTH: See Mental Hygiene
MENTAL HOSPITALS: See Hospitals, psychiatric; Hospitals, state
MENTAL HYGIENE clinic, W. Va., 51
committees, W. Va., 415
courses proposed for U. S. Military Academy, 327—OS
National Advisory Mental Health Council, (advocate training 600 in psychiatric work) 405; (meeting; membership) 409
National Mental Health Act, USPHS annual report, 702
National Mental Health Foundation, educational program, 1230
positions, examinations for, 562
MENTAL TENSION, hypnagogic hallucinations, 1253
sodium amytal test for latent anxiety, [Susselman] 506—ab
MENTALITY: See Intelligence
MEPACRINE: See Quinacrine
MEPERIDINE HYDROCHLORIDE (demerol; isonipecaine), addiction to, [Curry] ★243; (Council discusses) 850
addiction to; not classed as narcotic in Italy, [Musella] 198—C
*d*MERCAPTOPROPANOL: See BAL
MERCURY, deposition in eye, [Abramowicz] 352—ab
toxicity, acute poisoning, BAL for, [Longcope] 136—ab
toxicity of diuretics, [Ben-Asher] 348—ab
toxicity, tetany after diuresis, [Marshall] ★1007
MERKLE, Gland of: See Hibernation
MESANTOIN, treatment of epilepsy, [Lennox] 130—ab
METABOLISM: See also under names of specific substances
basal, effect of brown fat extracts on, 436
METAL: See Cadmium; Copper; Lead; Silver; Tantalum; Vitallium
METASTASES: See Cancer
METHEDRINE: See Desoxyephedrine
METHEMOGLOBINEMIA in infants from nitrates in well water, [Faucett] 271—ab
in infant from bismuth subnitrate used for diarrhea, methylene blue for [Wallace] ★1280
METHENAMINE, N.N.R. (Miller), 179
METHIONINE, prevention and treatment of liver injury (Council report) 107
treatment of anemias, [Gajdos] 574—ab
n-METHYLAMPHETAMINE (methedrine) in psychiatric diagnosis, [Simon] 724—ab
METHYL CHLORIDE, toxicity, 145; [Smith] 1309—ab
20-METHYLCHOLANTHRENE, what dosage to produce skin cancer in mice? 435
METHYLENEBIS (hydroxycoumarin): See Dicumarol
METHYLENE BLUE: See Methylthionine Chloride
METHYLENE DICHLORIDE (dichloromethane) toxicity, 145
METHYL METHACRYLATE, use in extrapleural pneumonolysis, [McCains] 1312—ab
METHYL-NAPHTHOQUINONE: See Menadione
METHYLOXAZOLIDINE: See Trimethadione
METHYL PHENYLETHYLHYDANTOIN, treatment of epilepsy, [Lennox] 130—ab; [Von Hagen] 889—ab
METHYLTHIONINE CHLORIDE, treatment of methemoglobinemia in infant from bismuth subnitrate, [Wallace] ★1280
METHYLTHIOURACIL, treatment of hyperthyroidism, 544—E; [Frisk] 574—ab; [Poate] 1172—ab
METHYLXANTHINES, effect on prothrombin activity, [Rieben] 69—ab
METREURYNTER, use in uterine bleeding; 74
METRIC SYSTEM, 1879, [Fishbein] ★177
METROPOLITAN Life Insurance Co., (tuberculosis statistics in U. S.), 698—E; (decline in mortality from syphilis) 709
MICE, mouse brain vaccine in epidemic encephalitis, [Sabin] ★281
mites on, rickettsialpox, [Huebner] 272—ab; [Greenberg & others] ★904
MICHIGAN, University of: See University
MICROBIOLOGY: See Bacteria; Bacteriology
MICROFILM service available to physicians by Army Medical Library, 789
MICROORGANISMS: See Bacteria
MICROPRINTS: See Microfilms
MICROSCOPY, phase contrast, 56
MICTURITION: See Urine, incontinence; Urine, suppression
MIDDLE AGE: See Age
MIDDLESEX Medical College, 1923, [Fishbein] ★932
MIDWIFERY: See Obstetrics
MIGRAINE: See also Headache
associated with menstruation, 812
experimental production, (reply) [Foldes] 280
psychosomatic disorders, [Harrington] ★670
treatment, dihydroergotamine (D. H. E. 45), [Pollock] 502—ab
treatment, nicotinic acid or ergotamine tartrate (gynergen), 812
treatment, testicular or ovarian preparations, [Bartstra] 1317—ab
MILITARY: See also Army, U. S.; Veterans; World War II
Citations: See World War II, Heroes
medicine, International Committee of, 262
medicine, International Congress of, June 1947, 262; 1231
medicine research by War Department, 950
training (universal) (War Department seeks adoption) 185—OS; (testimony favors) 250—OS
MILK, acidophilus, alteration of intestinal flora, 970
borne epidemic of diarrhea in newborn nursery, [Ensign] 271—ab
conference, England, 55
human, nursing by syphilitic mother, 810
pasteurization; fallacies of; William Brady, M. D., newspaper columnist, 249—E
production, efficiency, question of best animal feeds, 775—E
raw, brucellosis in Puerto Rico, [Hernandez Morales] 204—ab
Sugar: See Lactose
transmission of Brucella abortus, 1042
MILLER, THURMAN W., editor of JOURNAL, 1899, [Fishbein] ★474
MILLER Lecture: See Lectures
MINERAL: See also Gold; Iron; Lead; Silver
baths, Sul-Ray Effervescent 422—BI
Helio Minerals, 264—BI
mobilization from skeleton; lability of bone, 110—E
water, Buffalo, 422—BI
water, Colestin Natural, 568—BI
water, Hamby's Dawson Springs Water, 568—BI
MINERS, coal, A.M.A. resolution on Bituminous Coal Mine Wage Agreement, 35
coal (anthracite), pneumonoconiosis in, [Gooding] 894—ab
operators term Lewis health and welfare fund "economic blackmail," 556—OS
United Mine Workers Health Fund (Reference Committee report) 36; [Dickinson] ★1285
MINNESOTA, medical service areas in, [Dickinson] ★1014
ringworm of scalp; [Steves & Lynch] ★306
MINRA, 422—BI
MISCARRIAGE: See Abortion
MISSISSIPPI Valley Medical Society Contest: See Prizes
MITES: See also Acariasis; Mice
Bite Fever: See Tsutsugamushi Disease
grain, infest urinary tract, [Crance] 1243—ab
MITRAL VALVE, calcification of annulus fibrosus, [Ryland] 571—ab
MOHLER, CHARLES, death of assistant business manager of A.M.A., 45—OS
MOLD: See also Actinomyces; Penicillin
removal of odor from books, [Munkelt] 344—C
MOLE, Hydatidiform: See Placenta, tumors
MONONUCLEOSIS, INFECTIOUS, benign lymphocytic meningitis and, [Tidy] 728—ab
blood and bone marrow in, [Limarzi] 201—ab
diagnosis (differential) from rickettsialpox, [Greenberg & others] ★904
in puerperium and in newborn [Trincao] 142—ab
serum, agglutination of erythrocytes by, [Burnet] 67—ab
MONOXIDE: See Carbon Monoxide
MONUMENTS: See Physicians, monuments
MOOREHEAD, FREDERICK B., memorial fund, 1291
MORBIDITY: See Disease
Statistics: See Vital Statistics
MORPHINE addiction, sialorrhea and, 899
alcoholic beverages doped with, 1253
MORTALITY: See Accidents, fatal; Death; Infants; Maternity; Vital Statistics; etc.; under names of specific diseases as Leukemia; Syphilis
MOSQUITOES, control, cooperative, N. J., 1293
Cook County, 1292
efficacy of insecticidal sprays in aircraft, [Garnham] 146—ab
transported in old tires filled with water, 559; [Pratt] 725—ab
MOSS, California Spanish, antibiotic from, [Marshak] 1245—ab
MOTHERS: See Families; Maternity; Pregnancy
Milk: See Milk, human

MOTION PICTURES: See Moving Pictures
Reviews: See Moving Pictures, Medical
MOTION SICKNESS, mechanism, [Morton] 1306—ab
MOTOR Automatism: See Mental Tension
component of retinal stimuli; fusion movements, 713
MOTOR VEHICLES: See Automobiles
MOTT Foundation: See Foundations
MOULTON, GEORGE A., honored, 708
MOUSE: See Mice
MOUTH: See also Cheek; Jaws; Teeth; Tongue
Inflammation: See Stomatitis
surgery, intravenous barbiturates for, 812
Trench: See Angina, Vincent's
ulcer, grave eye disease with, Behcet's syndrome, [Thomas] 1246—ab
MOVEMENTS: See Eyes, movements; Motor
MOVING PICTURES, commentators fear production glamorizing use of drugs, 46—OS
film on prepayment plans (Reference Committee report), 36
Medical, Reviews of: See Moving Pictures, Medical (Reviews) *following*
new films added to A.M.A. library of films, 802
Walter Reed patients view film about amputee, "The Best Years of Our Lives"
MOVING PICTURES, MEDICAL (REVIEWS)
Anesthesia (Merck & Co.) 346
Convalescent Care and Rehabilitation of Patients with Injury to Spinal Cord, 1033
Energy Release from Food, 717
Neurosurgery in Overseas General Hospital, 1033
New Horizon (National Foundation for Infantile Paralysis) 346
Story of Menstruation, 1033
Technique of Anesthesia, 265
MUCOUS MEMBRANES: See Endometrium; Intestines
MULTIPLE Births: See Twins
MUMPS: See Parotitis, Epidemic
MURDER: See also Suicide
of physicians in 1946, 108—E
violent deaths in Cook County, Ill., 412
MURPHY, JOHN B., makes new proposals, 1912, [Fishbein] ★765; (accused of advertising) ★838
MURRAY-Dingell-Wagner Bill: See Wagner
MUSCLES: See also Cartilage; Tendons
Cardiac: See Myocardium
Cramps: See Cramps
Dystrophy: See Dystrophy
electromyography in differential diagnosis of ruptured cervical disk, [Brazier] 721—ab
Eye: See Orthoptics
gluteus medius weakness (severe), subtrochanteric osteotomy for, [Irwin] ★233
Inflammation: See Fibromyositis
lesions in arthritis, [Gibson] 67—ab
relaxation in abdominal surgery with pentothal-oxygen-curare, [Davidson] 1245—ab
scalenus anticus syndrome, scalenotomy for, [Tanna] 1241—ab
Spasm: See Spasm; Tetany
Sphincter: See Sphincter Muscles
Strength, Decrease of: See Myasthenia gravis
tibial (anterior), hernia; keloid (reply), [McKeever] 214
tibial (anterior), paralysis of leg from spasm of anterior tibial artery, [Holstein] 382
Tonus: See Dystonia
transplant (free myocardial), 621—E
MUSCULAR Power: See Energy
MUSEUM: See Health museum
MUSTARD Gas: See Dichlorethyl Sulfide
nitrogen mustard gas (1149), burns from, [Uhde] 889—ab
MUSTY odor, removal from books, [Munkelt] 344—C
MUTES: See Deaf-mutism
MYASTHENIA GRAVIS: See also Dystrophy, muscular
treatment, di-isopropyl-fluorophosphate (DFP) [Comroe] 886—ab; 1252
treatment, review of various methods, 1252
MYCOSIS: See also Actinomycosis
fungoides, [Lommen] 354—ab
MYELITIS: See Encephalomyelitis; Poliomyelitis; Spinal Cord, Inflammation
MYELOMA, multiple [Bayrd & Heck] ★147
multiple, stilbamidine and pentamidine plus diet low in protein for [Snapper] ★156
multiple, stilbamidine for, [Snapper] 64—ab
MYELOSCLEROSIS: See Osteosclerosis myelofibrosis
MYOCARDITIS, virus, 496
MYOCARDIUM, free transplants, 621—E
Infarction: See Thrombosis, coronary
MYOMA: See also Leiomyoma
uterine, radiation therapy, [Crossen & Crossen] ★593
MYOPIA, ciliary spasm, psychosomatic disorders, [Harrington] ★671
inheritance, 280
MYOSITIS: See Fibromyositis
MYOTONIA dystrophica: See Dystrophy, muscular
MYXEDEMA, Congenital: See Cretinism

MEDICOLEGAL ABSTRACTS

ABORTION: criminal; medical licenses; revocation of, 346
ARTHRITIS: trauma in relation to, 1302
workmen's Compensation Act in relation to, 1302
ASSAULT AND BATTERY: dentists; unauthorized extraction, 266
BLOOD: paternity; blood grouping tests to determine, 498
CANCER: trauma as cause of, 1170
workmen's compensation, 1170
CHIROPRACTIC PRACTICE ACTS: See also Medical Practice Acts
board of examiners; resolutions; validity of, 646
board of examiners; reversal of previous decision, 646
examinations; right of one member of examining board to give, 646
licenses; revocation; grounds; necessity for notice and hearing, 646
licenses; revocation; right of board, 646
CONTRACTS: hospital services; necessity for, who determines, 60
hospital services; refusal to furnish, 60
DENTAL PRACTICE ACTS: licenses; revocation; felony; conviction of, 126
licenses; revocation; felony; evidence of guilt, 126
licenses; revocation; rape, 126
DENTISTS: See Dental Practice Acts; Malpractice
EMPLOYEE: medical director as, 569
EVIDENCE: See also Malpractice; Privileged Communications; Workmen's Compensation Acts
blood grouping tests; paternity, 498
insanity; expert witness appointed by court; sufficiency of evidence, 1034
insanity; lay testimony; need for, 1034
scientific test; blood grouping to determine paternity, 498
witnesses, expert; credibility, 1034
witnesses, expert; necessity for in malpractice case, 423
witnesses, expert; preponderance; court not bound by, 1034
witnesses, expert; standards of care; competency to testify concerning, 423
FOOD AND DRUG ACTS: federal; "accompanying;" meaning of, 126
federal; printed matter accompanying drugs; misbranding, 126
HOSPITAL SERVICE PLANS: contracts; failure to furnish hospitalization, 60
hospitalization; when necessary; who determines, 60
HOSPITALS, CHARITABLE: intern; hospital's liability for negligence of, 884
negligence in employment of unlicensed dental intern, 884
taxes; criteria of charitable status, 266
taxes; exemption from, 266
HOSPITALS, GOVERNMENTAL: insane asylum; privileged communication in relation to, 199
HOSPITALS, IN GENERAL: failure to furnish hospital service; good faith of staff physician, 60
hospital records; privileged communication in relation to, 199
invitees; liability for injury to, 266
INSANITY: civil; sufficiency of evidence, 1034
civil; value of physician's certificate, 1034
INSURANCE, IN GENERAL: medical service plans, 718
medicine; practice of in relation to, 718
MALPRACTICE: dentists; expert testimony; necessary for, 884
dentists; extraction authorized, 266
dentists; operation; assault and battery, 266
dentists; operation; skill and care required, 423
dentists; saw; laceration from slipping, 423
dentists; skill and care required, 266
dentists; unlicensed dental intern, 884
evidence; witnesses, expert; necessity for, 423
evidence; witnesses, expert; standards of care; competency to testify concerning, 423
limitation of actions; accrual of right of action, 1239
limitation of actions; strict or substantial compliance with statutes, 1239
skill and care, dentists; competency of witness, 423
workmen's compensation act in relation to, 1170
MARRIAGE AND DIVORCE: adultery; abnormal length of pregnancy, 347
MEDICAL PRACTICE ACTS: chiropractic; as practice of medicine, 802
chiropractic; manipulation as treatment, 802
licenses; revocation; abortion; criminal, 346
licenses; revocation; abortion; sufficiency of evidence, 346
licenses; revocation; abortion; testimony of accomplice; admissibility of, 346
licenses; revocation; due process; denial of, 346
licenses; revocation; felony; narcotics; unlawful sale of, 60
licenses; revocation; narcotics; prescribing for addict, 60
licenses; revocation; rules of evidence applicable, 346
MEDICAL SERVICES: insurance in relation to contracts to provide, 718
PHARMACISTS: error in filling prescription, 1302
prescriptions; error in filling, 1302
PREGNANCY: gestation; length of, 347
PRESCRIPTION: as "sale" of drug, 60
error in filling; misdemeanor, 1302
error in filling; pharmacists liability, 1302
PRIVILEGED COMMUNICATIONS: consulting physician, 801
examining physician, 801
hospital records, 199
limitations; inmates of state hospital, 199
physicians of state hospital, 199
waiver; testimony in court; consulting physician, 801
waiver; testimony in court; one of several attending physicians, 801
SCIENTIFIC TESTS: See Evidence
SELECTIVE SERVICE AND TRAINING ACT: physician-veterans; right to former employment, 569
STATUTE OF LIMITATIONS: See Malpractice; limitation of actions
TAXES: hospitals; when charitable institution exempt, 266
TRAUMA: arthritis; evidence; witnesses, expert; conflict of medical testimony, 1302
cancer attributed to, 1170
disease attributed to, 1170
WORDS AND PHRASES: "accompanying," 126
"cancellation," 646
"prescribe," 60
"unreasonable," 569
WORKMEN'S COMPENSATION ACTS: arthritis; aggravation of; 1302
arthritis; trauma in relation to, 1302
cancer; trauma as cause of, 1170
claim; delay in filing; advice of physician, 964
claim; delay in filing; when excusable, 964
disease; trauma as cause of, 1170
evidence; conflict of medical testimony; denial of award, 1301
evidence; legal and medical theories, 964
eyes; blindness; uveitis; creosote fumes, 964
eyes; creosote fumes; uveitis, 964
eyes; uveitis; cause of, 964
malpractice by physician; liability for, 1170
uveitis; cause of, 964

N

N. N. R.: See American Medical Association New and Nonofficial Remedies; under names of specific products
NAILS, destroyed bed, restoration, 1044
fluorescence of, 1252
beta-NAPHTHOL treatment of fasciolopsis infection, 900
NAPHTHOQUINONES Having Vitamin K Activity: See Menadione; Vitamins K
NARCOTICS: See also Harrison Narcotic Law; Morphine
addiction, commentators fear moving pictures glamorizing, 46—OS
Illegal drug traffic, decrease in; but more arrests, 482—OS
order forms, lost or stolen, 492
NASAL: See Nose
Sinusitis: See Sinusitis, Nasal
Tube: See Duodenal Tube
NASOPHARYNGITIS: See Colds
NASOPHARYNX, radon applicator for asthma in children, [Ward & others] ★1060
NATIONAL: See also American; International; list of Societies at end of letter S
Advisory Cancer Council (conference on gastric cancer 187; (membership) 790
Advisory Health Council, (membership) 790; (medical research grants recommended) 1289
Advisory Mental Health Council, (training 600 in psychiatric work) 405—OS; (meeting; membership) 409
Board of Medical Examiners, (certification of general practitioners, Joint Committee report) 43; 943; (organized in 1915) [Fishbein] ★837; ★839
Cancer Institute, tests of new chemical compounds, 631—OS
Cancer Institute (Canadian), 1231
Committee for Employment of Handicapped, 46—OS
Conference on Health in Colleges, (3rd), 1217—E
Conference on Rural Health, (program) 326—OS; (proceedings) 778—OS; 860—OS
Council of Order of Doctors, old age insurance and, France, 1234
Council on Rehabilitation, 708
Defense: See also World War II
Defense, U. S. Dept. of, single department urged, 185—OS
Formulary published, 52
Foundation: See Foundations
Health Agency, 855—E; 868—OS
Health Bill: See Taft-Smith-Ball-Donnell Bill
Health Congress, (Reference Committee report), 36
Health Council, (expands program) 639
Health Program, Bill to Provide for: See Wagner-Murray-Dingell Bill

133
947

NATIONAL—Continued
Health Service Act (Beveridge Plan; British "White Paper"), (dental benefits under) [Josselyn] 125—C; (government plan for taking over voluntary hospitals) 195; [plebiscite taken by B. M. A. on, results) 261; (interferes with doctor's orders) 341; (controversy on, by medical profession) 419; (socialistic medical bodies and) 495; (conflict) 643; (B. M. A. decides to negotiate with Minister of Health) 797; 880; (Central Health Council for) 880; (plans for) 1295
Institute of Health (activities, USPHS annual report) 702; (Council discusses) 851
League of Medical Freedom, [Fishbein] ★761
League of Nursing Education, [Naffziger & others] 1168—C
Mental Health Act, (USPHS annual report), 702
Negro Health Week, March 30-April 6, 708
Neurologic Congress (1st), Italy, 1235
Organization for Public Health Nursing, [Naffziger & others] 1168—C
pharmaceutical benefits scheme, proposed, Australia, 1031
Research Council, (grants for research in endocrinology) 118; (Committee for Research in Problems of Sex) 492; (long range medical research program by) 1289
Safety Council, (report on toll of accidents) 564; (traffic safety awards) 1294
School Health Services Act, 632—OS
Science Foundation: See Foundations
Society for Prevention of Blindness Prize: See Prizes
Turkish Medical Congress (9th), 1236
University of Buenos Aires; 65 as retirement age, 196
NATIONS, United: See United Nations
NATUROPATHY practice, law authorizing repealed, Tenn., 415
NAUSEA: See Motion Sickness; Vomiting
NAVEL CORD: See Umbilical Cord
NAVY, UNITED STATES: See also World War II
assignments, 488
Commendation Ribbon; Medal: See World War II, Heroes
drive against vice, 112—OS
Hospitals: See Hospitals, Naval
Medical Center, (lectures at) 488; (lecture by P. R. Hawley) 703; (discusses medical aspects of atomic warfare) 1225
medical corps, 946—OS
medical corps, letters from men not allowed to resign; reply by Captain Eaton, 44
medical corps officers, examinations for, 48
Medical Officers Released by: See World War II, medical officers
medical officers (reserve), active duty for, 1225
medical officers (reserve), needed, 560
Nurses: See Nurses
physician veterans want hospitals to employ doctors with military service, 184—OS
promotions, 6 to rear admiral, 114
reserve officers, active duty for, 114; 331
School of Aviation Medicine and Research, 488
School of Tropical Medicine, Guam, 331
Surgeon General lauds hospital corpsmen, 699—OS
surgeons (acting assistant), suspend professional examinations for, 703
NAZIISM: See German occupation
NEARSIGHTEDNESS: See Myopia
NECK: See also Throat
cancer (primary), [Wieberdink] 208—ab
syndrome and rheumatic cervical perispondylitis [Belart] 141—ab; (correction) 337
NECROPSY: See Autopsies
NECROSIS: See Jaws, phossy; Kidneys; Pituitary
NEEDLE: See Radon
Biopsy: See Liver
NEGROES, Addison's disease in, [Conn] 128—ab
anemia (sickle cell) a race specific disease, 33—E
delegates, admission to A.M.A. House of Delegates, [Fishbein] ★101
National Negro Health Week, March 30-April 6, 708
negroid characteristics in infant, 280
neuropsychiatric aspects of porphyria, [Schneck] 202—ab
South African Negro or Bantu as parturient, [Heyns] 1037—ab
syphilis in, penicillin treatment failures, [Sternberg & Leifer] ★3
NEISSERIA gonorrheae infection: See Gonorrhea
NELSON'S Antacid Powder, 568—BI
NEMBUTAL: See Pentobarbital
NEOANTERGAN, antihistamine [Friedlaender] 1309—ab
NEOPLASMS: See Cancer; Sarcoma (cross reference); Tumors; under region or organ affected
NEOSTAM: See Stibamine glucoside
NEOSTIBOSAN, treatment in tuberculosis, [Rose] 269—ab
NEOSTIGMINE treatment of myasthenia gravis, 1252
treatment of muscle spasm in rheumatoid arthritis, [Wramner] 1248—ab
NEPHRECTOMY: See Kidneys excision
NEPHRITIS: See also Pyelonephritis
acute, prognosis for, 797
glomerular, sarcoidosis simulating, [Klinefelter] 722—ab
Tuberculous: See Kidneys, tuberculosis
NEPHROSIS: See Kidneys disease
NERVES: See also Ganglion; Nervous System; Neur-
Anesthesia: See Anesthesia
Blocking: See Nervous System, Sympathetic
Deafness: See Otosclerosis
exposed, repair, 56
facial, neurinoma of, [Kettel] 63—ab
impulse, energy required for each one, 693—ab
optic atrophy after hemorrhage from duodenal ulcer, [Levatin] 1306—ab
optic chiasm, [Lyle] ★519
optic, glaucomatous atrophy, [Barkan] ★530
optic retrobulbar [Lyle] ★518
optic, retrobulbar neuritis from digitalis, [Wagener] 200—ab
Paralysis: See Paralysis
peroneal palsy caused by crossing legs, [Nagler & Rangell] ★755
phrenic, temporary elimination in hemoptysis, [Stangl] 431—ab
Reflex: See Reflex
sciatic, stretching in acute rheumatic sciatica, [Cammaert] 968—ab
splanchnicectomy in hypertension with abnormal pyelograms, [Nesbit] 1311—ab
splanchnicectomy, late results, [Fontaine] 429—ab
supraorbital section, for hyperhidrosis, [Tarlov & Herz] ★476
Surgery: See under various subheads of Nerves; Neurosurgery
Syphilis: See Neurosyphilis
vagotomy for peptic ulcer, 181—E; [Bradley & others] ★459; [Miller & Davis] ★461; [Moore & others] ★741
vagotomy, gastric ulcer aggravated by, [Biegen & Kintner] ★1207
vagotomy, insulin test for intact nerve fibers after, [Hollander] 1307—ab
vagotomy (transthoracic) in peptic ulcer, [Ruffin] 1307—ab
vagus, humoral transmission of effects, 761—ab
vagus resection (transthoracic) in peptic ulcer, [Smith] 1313—ab
NERVOUS SYSTEM: See also Brain; Ganglion; Nerves; Nervous System, Sympathetic; Spinal Cord
Disease: See Encephalomyelitis
lesions in carbon monoxide poisoning, [Lhermitte] 806—ab
Surgery: See subheads under Nerves; Neurosurgery; Sympathectomy
Syphilis: See Neurosyphilis
torulosis, [Hassin] 1309—ab
NERVOUS SYSTEM, SYMPATHETIC, blocking in local shock, [Thomson] 66—ab
autonomic nervous system in ocular diseases, [Harrington] 719—ab
Surgery: See Sympathectomy
NERVOUS TENSION: See Mental Tension
NETHERLANDS, medical literature needed for libraries [Taylor] 345—C; [Kouwer] 715—C
new fees for doctors fixed by mutual assurance foundation, 1300
NEURALGIA: See Causalgia
NEURASTHENIA, tropical, 1216—E
NEURINOMA: See Fibroblastoma, perineural
NEURITIS, Retrobulbar: See Nerves, optic
Sciatic: See Sciatica
NEUROCIRCULATORY Asthenia: See Asthenia
NEURODERMATITIS of hands from food allergy, [Rowe] 720—ab
NEUROLOGY: See also Nerves; Nervous System; Neuro-
American Board of: See American Board
disease after throat and skin infections, [Bryson] 500—ab
manifestations in infectious hepatitis, [Weinstein] 887—ab
National Neurologic Congress (1st), Italy, 1235
practice, present trends, [Wilson & Rupp] ★509
residency training in, 186
Surgery in: See Neurosurgery
NEUROMAS, traumatic and amputation, [Ciesluk] 722—ab
NEURONITIS, late, after diphtheria, [Sampson] 129—ab
NEUROPATHY of facial nerve (Bell's palsy), [Bergstrom] 1318—ab
NEUROPSYCHIATRY: See also Psychiatry
Archivos de Neuro-Psiquiatria, new journal, 1295
aspects of porphyria, [Schneck] 202—ab
NEUROPSYCHOSIS: See Psychoneurosis
NEUROSIS: See also Psychoneurosis
anxiety, in porphyria, [Schneck] 202—ab
Cardiac: See Asthenia, neurocirculatory
NEUROSURGERY: See also Brain surgery; Nerves; Sympathectomy
in Overseas General Hospital (motion picture review) 1033
New York Society of Neurosurgeons, 116
South American Congress of (2nd), 258
NEUROSYPHILIS: See also Dementia Paralytica; Tabes Dorsalis
asymptomatic, prognosis, [Hahn] 425—ab
incidence, decline 25 years after beginning of malaria treatment, 482—OS
treatment, penicillin, [Rose & Solomon] ★5; [Koteen] 1241—ab
treatment, penicillin plus malaria or fever cabinet, [Rose & Solomon] ★6
NEUTROPENIA: See Agranulocytosis, Acute
NEW AND NONOFFICIAL REMEDIES: See American Medical Association; under names of specific drugs as Penicillin
NEW ENGLAND Journal of Medicine: See Journals
NEW GROWTHS: See Tumors
NEW HAMPSHIRE-Vermont Physicians Service, A.M.A. Council seal to, 112—OS
NEW YORK: See also Columbia University *Medical Record*; See Journals
rickettsialpox, [Greenberg & others] ★901
State Medical Society and A.M.A. 1884, [Fishbein] ★238; ★241
state positions in public health, [Amos] 124—C
University-Bellevue Medical Center grant, 256
University scroll commemorating founding of the A. M. A., 877
NEWBORN: See Infants, Newborn
NEWSPAPERS: See also Journals
advertising and state societies, [various authors] 628—ab
columnist (William Brady), on pasteurization of milk; 249—E
supervision of medical notes in lay press, Denmark, 123
NIACINAMIDE: See Acid, nicotinic
NICOTINIC Acid: See Acid, nicotinic
NIEMANN-PICK Disease, [Pfandler] 1247—ab
NIKETHAMIDE treatment for hiccup, 810
9-9-9 Program: See Interns and Internships
NITRATES, mannitol hexanitrate in hypertension, 1042
Mannitol Hexanitrate, N.N.R., (Smith-Dorsey) 179
in well water, methemoglobinemia in infants from, [Faucett] 271—ab
5-NITRO-2-FURALDEHYDE semicarbazone, use in dermatology, [Downing & others] ★299; [Morin] 963—C
NITROFURANS, use in dermatology, [Downing & others] ★299; [Morin] 963—C
NITROGEN balance, 247—E
mustard gas (1149), burns from, [Uhde] 889—ab
NITROGLYCERIN: See Glyceryl trinitrate
*tri*NITROTOLUENE, liver injury from, methionine for, (Council report) 107
NOBEL Prizes: See Prizes
NOCARDIA asteroides, actinomycosis from, [Kirby] 571—ab
NOISE, concussion deafness in 100 gunnery instructors, [Stewart] 63—ab
NOMENCLATURE: See Terminology
NORDIC Association of Surgeons, Sweden, 1030
NORMAL, what is "normal"? 1011—E
NORTHWESTERN University, (19 faculty members retire) 637; (Institute for Study of Rheumatic Fever) 791; (affiliates with Children's Memorial Hospital) 1023; (Medical Center) 1292
NORTON Medical Award: See Prizes
NORWAY, medical education in, 263
BCG vaccination in, [Hertzberg] 1247—ab
NOSE: See also Nasopharynx; Otorhinolaryngology
Accessory Sinuses: See Sinusitis, Nasal
carriers of hemolytic streptococcus, [Lemon] 137—ab; 322—E
Colds: See Colds; Hay Fever
granuloma (malignant), [Hargrove] 140—ab
hemorrhage, possible pseudohemophilia, 1320
rhinoscleroma, [Reyes] 269—ab
NOSEBLEED: See Nose hemorrhage
NOSTRUMS: See also under names of specific nostrums and diseases
advertising in J. A. M. A., [Fishbein] ★464; ★470; ★607; ★608; ★612; ★613; ★683; ★836
evil, England, 121
Listed by A. M. A.: See American Medical Association Bureau of Investigation
NOSTRUMS AND QUACKERY, first published 1912, [Fishbein] ★766
NOTALYSINE, initiator of bacteriolysis, [Hutter] 1247—ab
NOVOCAINE: See Procaine Hydrochloride
NUFFIELD Foundation: See Foundations
NULFEY Tablets, 264—BI
NURSERY, day, for children, report on, Sweden, 1300
for Newborn: See Hospitals, nursery
NURSES: See also Nursing
aides, volunteer, statistics, ★1076; ★1077
anesthetists, [Graham] ★99
anesthetists, in all hospitals, ★1077
Army appeals for more, 252
Army chief, conference, 1018
Army nurse corps (permanent), legislation, 947—OS; 1219—OS

NURSES—Continued
flight, graduate, Randolph Field, Texas, 1018
from 31 countries, Capital is host to, 1015—OS
labor attempts to coerce to join a union, England, 121
more education for, Royal College of Nursing decision, 1029
Naval nurse corps (permanent), legislation on, 947—OS; 1219—OS
Naval Reserve, 200 needed now, 114
practical, bill to end "fly by night" training schools for, 482—OS
practical, employment in hospitals, 631—OS
practical, symposium, W. Va., 190
practical, training programs, 794
Public Health: See also Nursing, public health
public health, examination, N. Y., 562
shortage, 110—E; 252; 556—OS
shortage, American Surgical Assn. resolution and statement, 1156—E; [Naffziger & others] 1168—C
shortage, England, 1165
shortage in 1918, [Fishbein] *844
shortage, ward helpers to relieve, New York, 490
statistics on, in all hospitals, *1075; *1076
student, enrolment, plans to stimulate, N. Y., 562
students, recruitment, nationwide, 327—OS
U.S.P.H.S., examinations for appointments, 253
wages (higher) requested, Sweden, 1030
NURSING and medicine a joint enterprise, 20—ab
center, opened in Chinatown, N. Y., 876
division, USPHS annual report, 702
Information Bureau booklet "Facts About Nursing, 1946", 191
needs of rural communities, committee report, [Sewell] 863—ab
Public Health: See also Nurses, public health
public health nursing week, 488; 790
schools of, advanced training for nurses, 1289
schools of in 1868, A.M.A. recommendations, [Fishbein] *26
schools of, in hospitals, *1075; *1076
schools of, short practical course, Mich., 1293
service, appalling corruption of Egyptian State hospitals, 1299
NURSING INFANT: See Infants, feeding
NUTRITION: See also Diet; Food
American Institute of, award, 51
A.M.A. Council on Foods and Nutrition: See American Medical Association
British Journal of Nutrition; 880
congenital malformations due to, [Keitel] 716—C
Deficiency: See also Beriberi; Pellagra; Scurvy; Starvation; Vitamins
deficiency, amblyopia in liberated prisoners, [Bloom] 63—ab
deficiency, and peptic ulcer, 263
deficiency in pregnancy, [Vilter] 206—ab
during pregnancy, [Keitel] 345—C
importance in tropical deterioration, 1216—E
in Switzerland during the war, [Fleisch] 354—ab
Nutrition Bulletin, new journal, 495
research needs in, [Jeans] *245
Revista de Nutrition, new journal, 118
Sociedad de Gastroenterologia y Nutricion, 343
teaching of, in medical schools, 1282—E
training, Gould Research Foundation, 708
value of fats with sucrose or lactose, [Ershoff] 1304—ab
Vitamins in: See Vitamins
NUXATED Iron, 883—BI
NYSTAGMUS, hereditary, [Rucker] 887—ab

O

O. B. C. Capsules, Genuine, 264—BI
OAK LEAF Cluster: See World War II, Heroes
OBESITY, constitutional aspects, [Freyhan] 1032—C; (reply), [Freed] 1032—C
different weight responses to same provocation, [Johnson] 1238—C
treatment, amphetamine sulfate, [Kunstadter] 808—C
treatment, Dr. Parrish's frauds, 57—BI
treatment, psychic factors, amphetamine sulfate and thyroid, [Freed] *369
OBITUARIES: See list of Deaths at end of letter D
OBSTETRICS: See also Abortion; Cesarean Section; Labor; Pregnancy; Puerperium
Anesthesia in: See Anesthesia
Congress of (6th), Argentine, 343
International Congress of, July 7, 1947, 416
progress in, 1889, [Fishbein] *317
Royal College of, controversy on National Health Service, England, 419
Sociedad Ycateca de Obstetricia y Ginecologia, Mexico, 118
OCCUPATIONAL Dermatoses: See Industrial Dermatoses
Diseases: See Industrial Diseases
Health: See Industrial Health
OCCUPATIONAL THERAPY (motion picture review) 802
technicians, schools approved by A.M.A., *1148
technicians, statistics, in all hospitals, *1077
technicians (trained) campaign for, 802
OCHSNER, E. H., attacks Dr. Billings, state medicine, 1921, [Fishbein] *925
OCULAR Symptoms: See Eyes; Vision
ODOR, removal from books, [Munkelt] 344—C
OFFICE: See also Physicians
of Scientific Research and Development Committee on Medical Research, 1295
OFFICERS: See Army, U. S.; Navy, U. S.; World War II, medical officers
OHIO: See Cleveland
State Medical Journal: See Journals
OIL, Iodized: See Iodized Oil
OINTMENTS containing estrogenic substances, (Council report) 1009
OKINAWANS, necropsies on, [Steiner] 133—ab
OKLAHOMA, Hoxsey—cancer charlatan, 774—E; (correction) 957
Medical Research Foundation: See Foundations
OLD AGE: See also Physicians, veteran
appendicitis (acute) in [Simpson] 1037—ab
benefits stressed in economic report, 184—OS
course in geriatrics, Buenos Aires, 882
food delivery scheme for aged to diminish hospital overcrowding, 643
geriatrics research laboratory, N. Y., 116; 414
health in aging population, 414
Insurance: See Social Security
peptic ulcer in, [Kiefer & McKell] *1055
prostatectomy in tenth decade, [Frater] 69—ab
research in geriatrics, Nuffield Foundation gift to Cambridge for, 1234
toxic goiter in, [Whishaw] 352—ab
wrist injuries in elderly patients, [Griffiths] 806—ab
OMENTUM, primary torsion, [Altemeier] 1036—ab
ONCHOCERCIASIS: See Filariasis
OPERA Tablets, 883—BI
OPERATION: See Surgery; under names of specific organs and diseases
Early Rising after: See Convalescence
Illegal: See Abortion, criminal
OPHTHALMIA neonatorum: See Conjunctivitis, infectious acute
OPHTHALMOLOGIST, rebates to, on prescribing, glasses, [Patek] 715—C; [Fishbein] *933
OPHTHALMOLOGY: See also Eyes; Orthoptics; Vision
American Board of: See American Board
Heed Ophthalmology Foundation fellowships, 1230
Hispano-American Society assembly (24th), 567
Oxford Opthalmological Congress award, 706
Pan American Congress of (3rd), 118; 492
penicillin (pure) in, [Soraby] 428—ab
OPTIC ATROPHY: See Nerves, optic
OPTIC NEURITIS: See Nerves, optic
OPTIC TRACT, [Lyle] *519
ORAL CAVITY: See Mouth
ORATIONS: See Lectures
ORCHITIS: See Testis inflammation
ORGANIZATIONS: See Societies, Medical; list of Societies and Other Organizations at end of letter S
ORGANIZED Labor: See Industrial Trade Unions
Medicine: See American Medical Association; Societies, Medical
ORIENTAL SORE: See Leishmaniasis, cutaneous
ORNITHOSIS: See Psittacosis
ORTHOPEDICS: See also Bones; Foot
Hospitals: See Hospitals, orthopedic
operations under refrigeration anesthesia, [Crossman & Allen] *380
procedures, local use of ice after, [Schaubel] 269—ab
surgery, choice of anesthesia in, [Dillon] *829
surgery, International Congress for, Sept. 1948, 1300
ORTHOPTICS council examinations, 794
task of orthoptist, (Council article) [Lancaster & Lancaster] *1211
OSLER-Weber-Rendu Disease: See Telangiectasia
OSSIFICATION: See Calcification (cross reference)
OSTEITIS deformans, Paget's disease, [Newman] 350—ab
OSTEOARTHRITIS, treatment, lactic acid injection, [Mawson] 352—ab
OSTEODYSTROPHY, renal, [Norman & others] *771
OSTEOGENESIS imperfecta: See Fragilitas ossium
OSTEOMYELITIS of lumbar spine in adult, [Freeman] 140—ab
treatment, bacitracin, [Melency & Johnson] *675
OSTEOPATHIA condensans disseminata: See Osteosclerosis myelofibrosis
OSTEOPATHS appear, 1897, [Fishbein] *468
challenge in treatment of pneumonia in 1922, [Fishbein] *929
to serve in Veterans Administration, 186
OSTEOPOROSIS, post-traumatic, Sudeck's atrophy, 577
mild, in renal osteodystrophy [Norman & others] *771
OSTEOSCLEROSIS myelofibrosis secondary in prostate cancer [Bersack] 131—ab
OTITIS MEDIA, acute, penicillin to prevent in scarlet fever, [Weiss] 206—ab
aero-otitis, treatment, [Behnke] *452
OTOLARYNGOLOGY: See also Ear; Larynx
request A. M. A. to publish journal in [Fishbein] *767; *931
OTORHINOLARYNGOLOGY: See also Ear; Larynx; Nose
French Society of, congress, 420
treatment, penicillin, 420
OTOSCLEROSIS, progress in, 938—E
OURINE, formerly sold as Aurine, 422—BI
OVARY, cancer, ratio in uterine myoma, [Crossen] *595
extracts for migraine, [Bartstra] 1317—ab
hormone and mammary cancer, 643
struma ovarii, [Smith] 722—ab
tumor, possible masculinizing, 213
tumors, dysgerminoma, [Custer] 66—ab
OVERVENTILATION: See Respiration, hyperventilation
OVUM: See Impregnation
OVERWEIGHT: See Obesity
OVIDUCTS, cancer, (primary), [Bancroft-Livingston] 894—ab
ligation, as contraceptive, effects, 1254
Pregnancy in: See Pregnancy, ectopic
OXALATES, effect on calcium metabolism, 1010—E
OXFORD Ophthalmological Congress award, 706
OXIDIZED cotton, hemostatic dressing in ano-rectal surgery, [Rosser] 893—ab
OXOPHENARSINE hydrochloride (mapharsen) poisoning, BAL for, [Cohen & others] *749
OXYGEN, deficiency, acclimatization to anoxia, [Houston] 650—ab
deficiency, angioscotoma in prolonged mild anoxia, [Smith] 1308—ab
deficiency, anoxia and respiration in aviators, [Behnke] *453
deficiency, glucose vs. anoxia in flying personnel, 776—E
deficiency, hypoxia in aviators, [Pitts] 1304—ab
liquid, converter for breathing purposes, 559
pentothal-curare to induce muscular relaxation in abdominal surgery, [Davison] 1245—ab
pressure gradient between maternal and fetal blood, [Barron] 207—ab
Quotient: See Metabolism, basal

P

PABULUM theory in causation of suppuration of wound, [Lyons] *215
PACIFIC, War in: See World War II
PAGET'S Disease of Bone: See Osteitis deformans
PAIN: See also Backache; Dysmenorrhea; Headache; Sciatica; under names of specific organs and regions as Abdomen
Abdominal Gas: See Flatulence
Burning: See Causalgia
in extremities in parkinsonism, 280
Precordial: See Angina Pectoris; Thrombosis, coronary
referred, fibromyositis and, [Sloboe] 803—ab
Relief of: See also Anesthesia
relief of, cortical excisions for, [Horrax] 273—ab
relief of unbearable pain by psychosurgery, [Watts] 891—ab
treatment, induced prolonged sleep, [Kaminski] 431—ab
PAINT: See Lacquer
PALATE exercises after bulbar poliomyelitis, 434
PALESTINE, foreign letter from, 496
PALLEN, MONTROSE A., accused of poisoning water in Croton reservoir in 1865, A. M. A. resolution protesting action, [Fishbein] *24
PALSY: See Paralysis
PAN AMERICAN: See also Inter-American; Latin America; South America
Congress of Ophthalmology (3rd), 118; 492
Congress on Tuberculosis, 563
Sanitary Bureau, (director retires) 639; (appointment of F. L. Soper) 714
PANARIS: See Paronychia
PANCOAST Superior Pulmonary Sulcus Tumor: See Thorax
PANCREAS: See also Diabetes Mellitus
calculi, [Dalgaard] 806—ab
cancer, 567
cancer of Islands of Langerhans without endocrine symptoms, [Hess] 141—ab; (correction) 337
cystic fibrosis, [Kennedy] 648—ab
extract (deproteinated) effect on coronary occlusion, 146
hyperplasia of Langerhans islets in fetuses of diabetics, [Hultquist] 1318—ab
inflammation (relapsing, chronic) 246—E
inflammation (traumatic), [Shallow] 1241—ab
Secretion: See also Insulin

PANCREAS—Continued
secretion, islet cell tumor with hyperinsulinism, [Marble] 271—ab
surgery, [Crile] 648—ab
tumors, argentaffin cells in, [Hultquist] 730—ab
tumors, islet adenoma in pregnancy, [Pompen] 1317—ab
tumors, islet cell tumor with hyperinsulinism, [Marble] 271—ab
PANCREATITIS: See Pancreas inflammation
PANHEMATOPOIESIS: See Blood formation
PANTABEE, assay of thiamine in, [Haskell] 645—C
PAPAVERINE hydrochloride to prevent posttraumatic pneumonia, [Phillips] *161
treatment of acute coronary occlusion, 357
PAPAYA Concentrate, Macu Brand, 264—BI
PAPER: See also Articles; Newspapers
dust, effect, 435
"White Paper": See National Health Service Act
PARA-AMINOBENZOIC ACID: See Acid
PARAGANGLIOMA: See Pheochromocytoma
PARALYSIS: See also Paraplegia
Agitans: See Parkinsonism
antirabic vaccine causes, [Bussell] 728—ab
Cerebral: See also Paralysis, spastic
cerebral palsy, Joint Committee for Research in Problems of, 1164
cerebral palsy, new center for, N. Y., 335
complications of spinal anesthesia, [Mason] 345—C
facial, rheumatic, [Bergstrom] 1318—ab
General: See Dementia Paralytica
Infantile: See Poliomyelitis
of anterior group of muscles of leg, [Holstein] 382—ab
of Bladder: See Bladder
peroneal palsy from crossing the legs, [Nagler & Rangell] *755
progressive bulbar palsy, treatment, 1044
Spastic: See also Paralysis, cerebral
spastic, rehabilitation hospital for children with, 256
PARANASAL Sinuses: See Sinusitis, Nasal
PARAPLEGIA centers of Veterans Administration, 1020
traumatic, physical therapy, [Guttmann] 1242—ab
traumatic, treatment, 495
PARASITES, Intestinal: See Ancylostomiasis
PARATHYROID, hyperparathyroidism (primary) [Norris] 63—ab
tumor, adenoma (recurrent), [Burk] 1314—ab
PARENTHOOD, Planned: See Contraception
PARENTS: See Maternity
PARESIS: See Dementia Paralytica
PARESTHESIAS, rheumatic cervical perispondylitis, [Belart] 141—ab; (correction) 337
PARIN, VASSILY V., visiting scientist returns to Moscow, 638
PARINAUD'S Conjunctivitis: See Leptothrichosis
PARKINSONISM, muscular cramps and pain in extremities in, 280
PARONYCHIA, panaris, [Domanig] 504—ab
PAROTITIS, EPIDEMIC (mumps), agglutination test for antibody, [Burnet] 67—ab
edema of anterior part of body in, [Chrysanthis] 354—ab
orchitis, [Nixon] 1243—ab
vaccination with formolized virus, [Stokes] 501—ab
vaccine (improved) 939—E
vaccine, [Habel] 427—ab
virus, attenuation of virulence with retention of antigenicity of, [Enders] 350—ab
PARRISH, EDWARD, frauds perish, 57—BI
PARROT Fever: See Psittacosis
PARTITION: See Labor
PASTEUR, LOUIS, death (50th anniversary), 262; [Fishbein] *466
exhibit of scientific work, 262
PASTEURELLA Tularensis Infection: See Tularemia
PASTEURIZATION: See Milk
PATENT MEDICINES: See Nostrums
PATENTS and A. M. A., [Fishbein] *471; *770; *839; *843
continued need for, 184—OS
medical, (Council discusses), 850
PATHOLOGY: See also Disease
American Board of: See American Board
Army Institute of, (new director: R. O. Dart) 252; (study on sudden death in young men) 325—E
clinical, 213
residency and fellowship programs must provide for training in, 697—E; 717
PATIENTS: See also Disease; Medical Service; Surgery; under names of specific disease as Scarlet Fever
bedridden, physicians accused of neglecting exercise, 699—OS
Convalescing: See Convalescence
Early Rising after Operation: See Convalescence
Hospital: See Hospitals
Transport of: See Ambulances
PAVLOV, IVAN, studies on conditioned reflexes, 713
PAY: See Wages
PEARS, homogenized, Libby's, 937
PEDIATRICS: See also Children; Infants
American Academy of, (study of child health service, A. M. A. Reference Committee report), 40
basic research needs in nutrition, [Jeans] *245
psychologic and psychiatric aspects of practice of, 1294
teaching, cooperative plan with U. of Michigan, 706
PEDICULI: See Lice
PEDICULOSIS, of head, DDT for, in children, [Kaiser] 130—ab; [Cowan] 1305—ab
treatment, DDT for, 733
PEIPING Union Medical College, Rockefeller Foundation terminates grants to, 564
PELLAGRA, glossitis, folic acid for, [Spies] 425—ab
in American war prisoners in Philippines, [Lewis] 501—ab
PELVIS, subtrochanteric osteotomy in poliomyelitis, [Irwin] *231
PENICILLIN, blood coagulating power, [Fradà] 354—ab; [Pelz] 800—C
blood levels, 145; (emulsions will prolong) [Putnam] 1174
calcium in wax and oil, N.N.R., (Abbott, Merrell, Wyeth) 477; (Premo) 1009
calcium troches, N.N.R., (description) 851; (Abbott; Schenley; Squibb; Upjohn) 851; (Bristol Laboratories) 1281
caronamide to inhibit excretion, clinical research on new drug, 1294
effect, compare with brain tissue extract on staphylococcus infections, [Nutini] 803—ab
effect on Endameba histolytica, [Knoll] 1242—ab
effect on vaccinia virus, [Gohar] 651—ab
in beeswax and peanut oil, [Hirsh] 1309—ab
inactivated, staphylococci inhibited by, [Hunwicke] 727—ab
N.N.R., tablets buffered, (description) 851; (Abbott; Bristol; Schenley; Squibb), 851
Nobel Prize winner in Italy: Dr. E. B. Chain, 1030
pure, in ophthalmology, [Sorsby] 428—ab
sodium, N.N.R., (Schenley) 543
solutions, stability of, treated with formaldehyde, 420
stored, potency against hemolytic staphylococci, [Pelczar] 720—ab
supply, removed from all distribution control, 112—OS
toxicity, after effects of prolonged use, 358
toxicity, contact dermatitis, [Friedlaender] 269—ab
toxicity, delayed allergic reaction, procaine intravenously for, [Rosellini] 204—ab
toxicity, in syphilis treatment, [Hill] 1244—ab
toxicity, jaundice, [Hughes] 352—ab
toxicity, pseudoglycosuria, [Boldyreff] 715—C
toxicity, sensitivity to sulfathiazole and *not* to penicillin, [Abram] 1301—C
toxicity, sensitization, give penicillin after? 435
toxicity, serum sickness, procaine intravenously in, [Dressler & Dwork] *849 [Abram] 1301—C
toxicity, urticaria, benadryl for, [Willcox] 428—ab; [Callaway] 891—ab
toxicity, urticaria, benadryl and pyribenzamine for, [Pillsbury & others] *1255
toxicity, urticaria, procaine for advise caution [Waldbott; Abram] 1301—C
Treatment: See also Abscess, peritonsillar; Agranulocytosis, Acute; Angina, Vincent's; Bartholin Gland; Breast abscess; Breast inflammation; Bronchiectasis; Diphtheria; Endocarditis; Frambesia; Gonorrhea; Infections; Intestines obstruction; Jaundice, spirochetal; Leptospirosis canicola; Liver abscess; Neurosyphilis; Otitis Media; Otorhinolaryngology; Pneumonia; Psittacosis; Relpasing Fever; Rheumatism; Scarlet Fever; Skin disease; Streptococcus carrier; Syphilis; Tetanus; Throat infections; Tonsils, infected; Urinary Tract infections; Wounds
treatment, cellular recovery after in endocarditis, [Moore] 724—ab
treatment, intra-articular, in arthritis, [Tucker] 892—ab
treatment, intraocular injections, [Van Heuven] 70—ab
treatment, intrapleural, in tuberculosis and empyema, [Callahan] 138—ab
treatment of endocarditis, effect of anticoagulants on, [Priest] 427—ab
treatment of endocarditis, large embolism during, [Fradà] 354—ab
treatment of scarlet fever; compared with convalescent serum and sulfonamides, [Hoyne & Brown] *661
treatment, ointment, topical treatment with, [Wright] 1305—ab
treatment, oral, in gonorrhea, [Bushby] 574—ab
PENICILLIN—Continued
treatment (X, G and commercial) of scarlet fever; compared with antitoxin and symptomatic therapy, [Hirsh & others] *657
treatment plus fever in neurosyphilis, [Rose & Solomon] *6
treatment plus sodium para-aminohippurate and heparin in endocarditis, [Loewe] 61—ab
treatment plus sulfadiazine of pneumonia, [Dowling] 1171—ab
treatment plus sulfadiazine, routine use in appendectomy, [Griffin & others] *907
treatment plus sulfonamide for peritonitis, [Brown] 1241—ab
treatment plus sulfonamide for pneumococcic meningitis in children, [Ross] 892—ab
treatment plus sulfonamide of trachoma, [Lavery] 67—ab
treatment, resistance, [Dowling] 270—ab
treatment, resistance (acquired) of Treponema pallidum, 1282—E
treatment, symposium on, in British Medical Bulletin, 478—E
treatment vs. bacitracin, [Meleney & Johnson] *680
PENICILLIUM notatum, filtrates of, antidotal property, 33—E
notatum Westling, notalysine, [Hutter] 1247—ab
PENIS: See also Circumcision
angulation, due to short frenum, 812
Erection of: See Priapism
tuberculosis, [Lewis] 965—ab
PENTAMIDINE and stilbamidine plus diet low in protein in myeloma, [Snapper] *136
PENTAQUINE, Council name for SN 13276, 132: 990, Dec. 21, 1946
PENTOBARBITAL, convulsive seizures after withdrawal, [Osgood] *104
PENTOTHAL SODIUM, intravenous, for oral surgery, 812
oxygen-curare for muscular relaxation in abdominal surgery, [Davison] 1245—ab
PEOPLE: See Population
PEPTIC ULCER, complications: diabetes, [Wood] 1240—ab
diagnosis, blood bilirubin to differentiate from portal cirrhosis, [Navarro] 351—ab
diagnosis (roentgen) of duodenal ulcer, [Brown] 1245—ab
diagnosis (roentgen), perforation during, [Schilling] 273—ab
diagnosis, roentgen and clinical aspects, [Krisnapoller] 430—ab
electrocardiographic findings, [Ørning] 208—ab
hemorrhage from, [Heuer] 725—ab
hemorrhage from duodenal ulcer, amaurosis in, [Forgarasi] 1248—ab
hemorrhage from duodenal ulcer, optic nerve atrophy after, [Levatin] 1306—ab
in aged, [Kiefer & McKell] *1055
in South Australia, [Linn] 728—ab
incidence in hematemesis, [Cluer] 274—ab
nutritional deficiencies and, 263
perforated gastroduodenal ulcer, [Baritell] 1314—ab
perforating gastric or duodenal ulcer, 1936-1944, [Saxholm] 1318—ab
perforation during roentgen examination, [Schilling] 273—ab
perforation of duodenal ulcer, [Graham] 647—ab; (amaurosis in) [Forgarasi] 1248—ab
surgical treatment, dorsolumbar sympathectomy aggravates gastric ulcer, [Biegen & Kintner] *1207
surgical treatment, gastric neurectomy, [Bradley & others] *459
surgical treatment, in gastric and duodenal ulcers, [Hinton] 500—ab
surgical treatment, subtotal gastrectomy for duodenal ulcer, [Allen] 132—ab
surgical treatment, transthoracic vagotomy, [Ruffin] 1307—ab
surgical treatment, transthoracic vagus resection, [Smith] 1313—ab
surgical treatment, vagotomy, 181—E; [Bradley & others] *459; [Miller & Davis] *461; [Moore & others] *741
surgical treatment, vagotomy, insulin test for intact nerve fibers, [Hollander] 1307—ab
treatment, aluminum hydroxide gel and magnesium hydroxide, [Jankelson] 1240—ab
treatment, enterogastrone, [Greengard] 1307—ab
treatment, protein hydrolysates and dextrimaltose, [Co Tui] 1312—ab
treatment, protein hydrolysates, [Ruggiero] 272—ab
PERFORATION: See Ear; Peptic Ulcer
PERIARTERITIS nodosa, etiologic role of allergy in, 620—E; 776—E
PERIODICALS: See Journals
PERITONEUM, dialysis for anuria, [Reid] 503—ab
irrigation in acute renal failure, [Fine] 426—ab; [Goodyear & Beard] *1208
rebound tenderness in abdominal disease and Rovsing's sign, 508
tumors, primary retroperitoneal, [Donnelly] 649—ab

PERITONITIS, control with penicillin and sulfadiazine; experiments with streptomycin, [Griffin & others] *907
PERNICIOUS Anemia: See Anemia, Pernicious
PERSONALITY: See Constitution; Psychosomatic Medicine
PERSPIRATION: See Sweat
PERTUSSIS: See Whooping Cough
PETHIDINE: See Meperidine
PETIT MAL: See Epilepsy
PHANTOM Limb: See Amputation
PHARMACEUTICALS: See also Drugs; Pharmacology; Pharmacopeia; etc.
national benefits, scheme proposed, Australia, 1031
PHARMACISTS: See also Medicolegal Abstract at end of letter M
appointments, examination for, 409
statistics on, in all hospitals, *1077
PHARMACOLOGY: See also Drugs
residency and fellowship programs must provide training in, 697—E; 717
PHARMACOPEIA: See also Formulary
U. S., [Fishbein] *175; *176
U. S., Convention, 1915, [Fishbein] *765
PHARMACY, A. M. A. Council on: See American Medical Association
PHARYNGITIS, of unknown cause, [Commission on Acute Respiratory Diseases] *588
recurrent, 358
PHARYNX: See Nasopharynx
PHENARSINE: See Oxophenarsine
PHENOBARBITAL, N.N.R., (Miller) 543
convulsive seizures after withdrawal, [Osgood] *104
Phenolix Elixir, 422—BI
sensitivity to amigen, [Ratner] 497—C
treatment of epilepsy with hydantal, [Von Hagen] 889—ab
PHENOLIX Elixir Phenobarbital, 422—BI
PHENYL MERCURIC borate toxicity, used as preservative for plasma? 214
PHEOCHROMOCYTOMA of adrenal medulla, cause of malignant hypertension, [Washington] 724—ab
of adrenals, [Espersen] 142—ab
PHI Delta Epsilon Lecture: See Lectures
PHILATELY: See Postage Stamps
PHILIPPINE Journal of Surgery: See Journals
PHLEBITIS: See Pylethrombophlebitis; Thrombophlebitis
PHLEBOTHROMBOSIS, [Aycock & Hendrick] *1259
in gynecologic patients, [Meigs] 1035—ab
treatment, [Allen & others] *1268
PHLEBOTOMY, for venous thrombosis and pulmonary embolism, [Allen & others] *1268
PHONOGRAPH recordings of cardiovascular and respiratory sounds, [Stokes] 429—ab
PHOSPHATASE in Blood: See Blood
PHOSPHORUS necrosis, extermination of "phossy jaw," 643
radioactive, external use, [Low-Beer] 65—ab
radioactive, for primary polycythemia, [Erf] 62—ab
PHOTOELECTRIC sulfobromophthalein sodium liver function test, [Mateer & others] *913
PHOTOFLUOROGRAPHY in tuberculosis case finding, [Birkelo & others] *359; 399—E; [Koynat] 963—C
PHOTOGRAPHY: See also Microfilms; Moving Pictures
clinical photographers in all hospitals, *1077
PHOTOSENSITIVITY: See Light, sensitivity to
PHOTOSYNTHESIS: See Chlorophyll
PHYSICAL DEFECTS: See also Handicapped
in selective service registrants in final months of the war, 854—E
PHYSICAL EDUCATION and Training: See Exercise; Health education
PHYSICAL EXAMINATION: See also Physical Fitness
annual, for U. S. Army personnel, 47
Industrial: See Industrial Health
of school children, 1292
of selective service registrants in final months of war, 854—E
PHYSICAL EXERCISE: See Exercise
PHYSICAL FITNESS: See also Physical Defects
A. M. A. project, 945—OS
Joint Committee report, 44
PHYSICAL MEDICINE: See also Physical Therapy
A. M. A. Council on: See American Medical Association
New Horizon (motion picture review), 346
PHYSICAL REHABILITATION: See Rehabilitation
PHYSICAL THERAPY: See also Cold, therapeutic use; Diathermy; Heat, therapeutic use; Physical Medicine; Radium; Roentgen Therapy
in traumatic paraplegia, [Guttmann] 1242—ab
technicians, school for, approved by A. M. A., *1149
technicians, statistics in all hospitals, *1077
PHYSICALLY HANDICAPPED: See Handicapped
PHYSICIANS: See also Economics, Medical; Medical Jurisprudence; Medical Service; Medicine, profession of; Surgeons
accused of neglecting exercise for bedridden patients, 699—OS
PHYSICIANS—Continued
advertising by, [Fishbein] *838
American College of, research fellowships awarded, 492
A. M. A. Judicial Council asked to define, 1924, [Fishbein] *933
American, Serving Overseas: See World War II
automobile priorities for (Joint Committee report), 44
avocations, American Physicians Literary Guild, 257; 1165
avocations, bridge champion, 788
avocations, Physicians Art Association, Mass., 1023
Awards to: See Prizes; World War II, Heroes
choice of, freedom by insured, in 1917, [Fishbein] *841
Commissions (military): See Army, U. S.; Navy, U. S.; World War II
Consulting: See Consultants
Courses for: See Education, Medical, graduate
cultists relationships, [Fishbein] *100; *175; *924; *933
Danish, Domus Medica, 961
Deaths: See also Deaths at end of letter D
deaths, editorial first published in J. A. M. A. Jan. 9, 1904, [Fishbein] *612
deaths in 1946, 108—E
DESK REFERENCE OF MEDICAL ECONOMICS, [Rothschild] 124—C
diet cards available for those interested in infant and child feeding, W. Va., 116
Directory of: See American Board of Ophthalmology; American Medical Directory; American Medical Association, Directory Department
Distinguished Service Medal: See World War II, Heroes
Education of: See Education, Medical
Ethics: See Ethics, Medical
Expert Witness: See Evidence
Fees: See Fees
Fellowships: See Fellowships
Fellowships in A. M. A.: See American Medical Association
German, atrocities committed by, Dr. Ivy's report, A.M.A. Judicial Council report, 35; [Wertham] 645—C
Graduate Courses; Work: See Education, Medical, graduate
Graduate Work: See Education, Medical
group insurance as it affects, [Rees] *613
Heroic Action: See World War II, Heroes
Honorably Discharged: See World War II, medical officers
Hospital: See Hospitals
Impostors Preying on: See Impostors
in civilian practice during war: A. M. A. Committee questionnaire, 480—E
in politics, physician and dentist U. S. legislators, 956
in politics, physicians in National Assembly, Turkey, 1236
Income: See Fees; Wages
Income Tax: See Tax
Industrial: Industrial Relations: See Industrial Health
interest in his medical society, what technic most successful, [various authors] 629—ab
Investments, [Smith] *27
join with lawyers in combating court problems, 631—OS
Killed in Action: See World War II, Heroes
labor attempts to coerce to join a union, England, 121
Lectures Honoring: See Lectures
Licensing: See Licensure
location for practice of physician veterans, 944—OS
location of, at every crossroad not the solution, [Shoulders] 866—ab
locum tenens, Denmark, 123
Medals for: See Prizes; World War II, Heroes
medical delegation visits Buenos Aires, 882
Medical Practitioners Union, and National Health Service, 495
Medical Responsibility: See Medical Jurisprudence; Medicolegal Abstracts at end of letter M
Memorial: See also Fellowships; Lectures; Physicians, monuments; Prizes
memorial fund, Bleckwenn, 1230
memorial, Gorgas, 1923, [Fishbein] *931
memorial, Meek (Walter Joseph) Fund aid for superior students, 492
memorial, Moorehead (Frederick B.) fund, 1291
memorial, *S. S. Frederick Banting*, a liberty ship, 1294
microfilm service by Army Medical Library available to, 789
Military Service: See World War II
Monument: See also Physicians memorial
monument to, Benjamin Rush, [Fishbein] *311; *315; *316
monuments, battle of, [Fishbein] *466
National Council of Order of Doctors and old age insurance, France, 1234
Negro, admission of, to A. M. A. House of Delegates, [Fishbein] *101
nonimmigrant entry authorized for, Puerto Rico, 638
office rents, oppose increase in, Ore., 1229
Payment of: See Fees
Portraits: See Portraits (cross reference)
PHYSICIANS—Continued
positions for, Kelleys Island needs a doctor, Ohio, 336
positions open for research in psychiatry, 337
positions open, in public health, New York State, [Amos] 124—C
positions open, Psychiatric Personnel Placement Service, 117
positions open, specialists wanted for U. S. government positions, 48
positions open, U. S. Civil Service, 951
Practicing: See also Medicine, practice; Physicians, supply
practicing, general practitioners on hospital staffs, [Garlepy] 1169—C
Practicing in Groups: See Medicine, group practice
practicing, specialty board for general practitioners (Joint Committee report), 43; (also Indiana bylaws) 942—OS
Prescriptions: See Prescriptions
Prizes for: See Prizes
Residencies: See Residents and Residencies
responsibility of individual physician, [Sargent] 550—ab
rural, scholarships to provide, (Ind..) 489; (Ill.) 706
Salaries: See Wages
Separated from the Service: See World War II, medical officers
Service by: See Medical Service; Medical Service Plans; Physicians, supply
Society of General Physicians organized, 491
Soviet: See under Russia
Specialization by: See Specialization; Specialties
strike settled at 2 of Stockholm's largest hospitals, 421
Supply: See also Physicians, location
supply, critical shortage, U. S., 699—OS
supply, distribution of doctors, Denmark, 961
supply, methods of bringing and holding doctors in rural areas, [Humphrey] 778—ab; [Starr] 779—ab; [Mulholland] 861—ab
supply, 1960 will require 27,000 additional, [Parran] *1649
supply, principles of retail trading areas applied to, 1011—E; [Dickinson] *1014
supply, shortage, Netherlands, 712
supply, shortages of doctors, nurses and hospitals, 556—OS
supply, Washington, D. C., 556—OS
Swindling: See Impostors
urged to use "plain English," 1015—OS
veteran, (Dr. Cary, 75) 793; (50 years in practice, Pennsylvania honors) 1164; (Dr. Waggener, 94) 1228
veteran, Dr. Cary (75th birthday) 793
Veterans of World War II: See Veterans, physician
War Service: See Veterans; World War II, medical officers
welter of material aids, 1210—ab
women, [Fishbein] *101; *607
women, A. M. A. attitudes on, [Fishbein] *26
women, first A. M. A. member: Dr. Sarah Hackett Stevenson, [Fishbein] *175
young, tribute by Brig. Gen. Raymond W. Bliss to, 481—E
PHYSIOLOGY, residency and fellowship must provide training in, 697—E; 717
PHYSIOTHERAPY: See Physical Therapy
PHYSIQUE: See Constitution
PHYSOSTIGMINE, 733—ab
PICK-Niemann Disease: See Niemann-Pick Disease
PICRIC Acid: See Trinitrophenol
PICTURES: See Moving Pictures; Photography; Portraits (cross reference)
PIES, cream, food poisoning from, Mich., 792
PIGEONS, psittacosis in children, [Meyer & Eddie] *824
PIGMENT: See also Dyes (cross reference)
green, and etiology of chloroma, [Humble] 729—ab
PIGMENTATION: See also Dermatitis, Ochenoid pigmentary; Melanosis; Retinitis pigmentosa
after burns from boiling water splashed through a nylon stocking, 436
PILOCARPINE and seborrhea, 577
PILONIDAL sinus disease, management, [Rosser & Kerr] *1003
wound (open) healing, [Blaisdell] *916
PILOTS: See Aviation
PINEAPPLE, homogenized, Libby's, 937
PITKIN menstruum, heparin in, for venous thromboembolic disease, [Loewe & Hirsch] *1263
PITRESSIN treatment for hypertension, 898
PITUITARY: See also Diabetes Insipidus
Disease: See Acromegaly
growth hormone, 898
hypertrophy and hibernation, 656
necrosis (postpartum) with diabetes insipidus, [Spain] 727—ab
Posterior: See also Pitressin
posterior injection, and ergonovine, combine in same syringe? 1044
posterior injection in prolonged labor, [Reid] 425—ab
posterior solution, N.N.R., (Harrower) 695

133
947

PLACENTA: See also Amniotic Fluid; Fetus
accreta, possible recurrence, 810
tumor, Holman's gift to establish registry of hydatidiform mole, 192
PLAGUE and yellow fever, 563
bubonic, sulfadiazine for, [Huang] 571—ab
control by live vaccine, [Grasset] 1316—ab
in rodents, Nebr., USPHS report, 702
sylvatic, found in Peru, 957
treatment, antiserum and sulfadiazine, [Platzer] 206—ab
PLANES: See Aviation
PLANNED Parenthood: See Contraception
PLANTS: See Chlorophyll; Pollen; Ragweed; Rhus
PLASMA: See subheads under Blood; Blood Transfusion; Serum
PLASMOCHIN Treatment: See Malaria
PLASTER, Adhesive: See Adhesive
PLASTICS: bib suffocates infant, 121
fibrinogen, tissue reactions induced by, [Bailey] 721—ab
PLATELETS: See Purpura, thrombopenic
PLATINUM chloride use in cornea tattooing, (reply) [Knapp] 358
PLAYING Cards: See Bridge
PLEURA Effusion: See Pleurisy with effusion
intrapleural penicillin in tuberculosis and empyema, [Callahan] 138—ab
Tuberculosis: See Pleurisy, tuberculous
PLEURISY due to amebiasis, [Carruthers] 1246—ab
Purulent: See Empyema
tuberculous, surgical treatment, [Harbitz] 142—ab
with effusion, indication for artificial pneumothorax? 797
with effusion, pathogenesis, [Thompson] 887—ab
PLEUROPNEUMONIA-like organisms, relation to Reiter's disease, etc. [Wallerstein] 137—ab
PLOTZ Foundation: See Foundations
PLUMBISM: See Lead poisoning
PLUMMER-VINSON Syndrome, [Savilahti] 274—ab
PNEUMATOCELE during pneumonia in children, [Almklov] 570—ab
PNEUMOCOCCUS, factor in whole wheat bread beneficial to parasitic growth of, 401—E
Meningitis: See Meningitis
Pneumonia: See Pneumonia
PNEUMOCONIOSIS: See Pneumonoconiosis
PNEUMOGRAM: See Brain
PNEUMONECTOMY: See Lungs surgery
PNEUMONIA, atypical primary, [McCoy] 65—ab; [Eaton] 1303—ab
complications, erythema multiforme exudativum, [Dingle & others] 888—ab
epidemiologic pneumococcic, 323—E
incidence, weekly report, Mo., 1163
pneumatocele during, in children, [Almklov] 570—ab
post-traumatic, after nonpenetrating lung injuries; prevent with penicillin or sulfadiazine, atropine papaverine, [Phillips] ★161
relation to Reiter's disease, arthritis and colitis, [Wallerstein] 137—ab
staphylococcic primary, penicillin for, [Davis] 1310—ab
treatment, osteopathic challenge by George A. Still in 1922, [Fishbein] ★929
treatment, penicillin and sulfadiazine, [Dowling] 1171—ab
tularemic primary, streptomycin for, [Smith] 205—ab
Virus: See Pneumonia, atypical primary
PNEUMONECTOMY: See Lungs, surgery
PNEUMOCONIOSIS, effect of paper dust, 435
asbestosis, histology of, [Noro] 652—ab
in anthracite miners, [Gooding] 894—ab
in cutters of fireproof brick, 644
in dock workers, [Dunner] 428—ab
silicosis, 643
silicosis and hematogenous tuberculosis, [Zollinger] 1038—ab
silicosis, hematologic study in, [Heimann] 1244—ab
thresher's lung, [Tornell] 504—ab
PNEUMONOLYSIS: See Lungs, surgery
PNEUMOTHORAX, spontaneous simple, [Niehaus] 1304—ab
PNEUMOTHORAX, ARTIFICIAL: See also Tuberculosis of Lung
pleurisy with effusion indication for? 797
results, [Branday] 888—ab
POISON Ivy: See Rhus
POISONING: See also Arsenic; Bromide; Lead; Mercury
acute, value of gastric lavage in, 545—E; (technic) [Kantor] 1238—C
Food: See Food
Industrial: See Industrial Dermatoses; Industrial Diseases
POLAND, Swedes help fight venereal disease in, 1030
POLIOENCEPHALITIS, hemorrhagic, Wernicke's encephalopathy, [de Wardener] 1246—ab
POLIOMYELITIS, abortive; diagnosis, [Bridge] 271—ab
bulbar, exercise for palate after, 434
clinic for patients, Cal., 636
epidemic in New Haven, [Wenner] 1314—ab
epidemic in 1891, [Fishbein] ★386
POLIOMYELITIS—Continued
epidemic, 1946, 709
etiology, water in [Scobey] 721—ab
Georgia Warm Springs Foundation, 1163
immunity (climate), [Bridge] 576—ab
National Foundation for Infantile Paralysis, (March of Dimes) 117; 185—OS; (appoint H. M. Weaver research director) 257; (research meeting) 492; (grant to train medical record librarians) 622—E; 639; (grant for research on muscle physiology) 792
preparalytic, gelsemium in, [Holman] 136—ab
seminar on, Nebr., 490
subclinical, [Casey] 886—ab
subclinical, spinal fluid protein in, [Andelman] 65—ab
symposium, Hennepin County Medical Society, 1163
training conferences on, 492
transmission, [Van Rooyen] 428—ab
transmission to rodents, 1217—E
treatment, subtrochanteric osteotomy, [Irwin] ★231
vaccine, Sweden, 421
virus, fatal infection in laboratory worker, [Wenner] 1303—ab
POLITICS, Physicians in: See Physicians
POLLEN desensitization in pregnancy, 1174
extracts, research on, grant by Marcelle cosmetics, 878
POLLINOSIS: See Hay Fever
POLYARTHRITIS: See Arthritis
POLYCYTHEMIA, primary, radiophosphorus for, [Erf] 62—ab
POLYURIA: See Diabetes Insipidus
POPULATION: See also Vital Statistics
Policy Commission, Japan's eugenics program, 185—OS
PORENCEPHALY, [Pendergrass] 130—ab
PORK: See also Trichinosis
best animal feeds, effect on milk supply, 775—E
PORPHYRIA, acute, [Jorgensen] 1316—ab
acute, fatal case, [Abbott] 723—ab
chronic, complicating pregnancy, [Linas & others] ★105
neuropsychiatric aspects, [Schneck] 202—ab
PORTAL VEIN, obstruction in diabetic child, 279
pylothrombophlebitis, streptomycin for, [Wishart & Peterson] ★539
PORTRAITS: See under names of individuals as Guerry; McClaran
POSITION in Space: See Posture
POSITIONS Open: See Physicians; U. S. Government
POST products, attacks centered on J. A. M. A. editor: Dr. Simmons, in 1910 [Fishbein] ★762
POSTAGE STAMP: See also Mail
honors A. M. A. centennial, 1219—OS
POSTGRADUATE *Medicine*: See Journals
Schools: See Schools, Medical
Work: See Education, Medical, graduate
POSTMORTEM: See Autopsies; Death
POSTOPERATIVE: See Surgery
POSTPARTUM: See Puerperium
POSTURE, Early Rising after Operation, etc.: See Convalescence
peroneal palsy from crossing legs, [Nagler & Rangell] ★755
position of relief in intestinal strangulation, [Evans & Bigger] ★514
POSTWAR Medical Service, Committee on: See American Medical Association Joint Committee for Coordination of Medical Activities
POTASSIUM bitartrate, dusting powders for rubber gloves, 1218—E
intoxication, [Finch] 61—ab
salts treatment of myasthenia gravis, 1252
POWDER: See Dusting Powder
POWER: See Energy
Atomic: See Atomic Energy
POWERS, PHILIP N., on Presidential Scientific Board, 185—OS
POX Disease (new): See Rickettsialpox
PRACTITIONERS: See Physicians practicing
Drugless: See Cults
PREFRONTAL Leukotomy: See Brain surgery
PREGNANCY: See also Fetus; Impregnation; Labor; Maternity; Obstetrics; Placenta; Puerperium; Reproduction; Medicolegal Abstracts at end of letter M
blood (maternal-fetal), oxygen pressure gradient [Barron] 207—ab
blood picture in 9th month, 1254
complications: adenoma of islands of Langerhans, [Pompen] 1317—ab
complications: amebiasis, 1042
complications: brucellosis, 357
complications: diabetes; fetal hyperplasia of Langerhans islets, [Hultquist] 1318—ab
complications: endometriosis, 436
complications: epilepsy, [Burnett] 1037—ab
complications: heartburn, [Roth] 427—ab
complications: hyperthyroidism, thiouracil for, 73
complications: porphyria (chronic), [Linas & others] ★105
complications: regional enteritis, [Williams] 966—ab
complications: rubella and chickenpox; defects in child, [Swan] 1316—ab
PREGNANCY—Continued
complications: rubella; congenital deafness in child [Hopkins] 268—ab; [Clayton-Jones] 1316—ab
complications: rubella; deaf-mutism in child, 1012
complications: thyrotoxicosis, 655
complications: toxoplasmosis probably not recur in subsequent pregnancies, 970
complications: uterine contractions painful, 214
diagnosis, breast striae, 358
diagnosis, melanophore reaction, [de Bourgraaf] 730—ab
diagnosis, metreurynter in uterine bleeding; positive Aschheim-Zondek test, 74
diet deficiency in, [Vilter] 206—ab
diet, nutrition during, [Keitel] 345—C
ectopic, fetal bones in bladder, [Forshaw] 429—ab
ectopic in cervical mucosa, [Schneider] 131—ab
ectopic (tubal), conservative surgery in, [Graham F.] 730—ab
electric shock during, cause fetal death? 280
Interruption of: See Abortion
interval (prolonged) between, 578
intrauterine respiration of fetus, [Windle & Becker] 125—C
Multiple: See Twins
pollen desensitization in, 1174
Protection from: See Contraception
Rh factor, 577
roentgen therapy during, cause congenital malformations, [Keitel] 716—C
sulfonamides used in, effect on fetus, 970
Toxemia of: See Eclampsia
weight gain in, vs. weight of newborn [Klein] 129—ab
PREMEDICAL Work: See Education, Medical
PREPAREDNESS, Medical: See World War II
PREPAYMENT Plans: See Hospitals, expense insurance; Medical Service Plans; Medicolegal Abstracts at end of letter M
PREPUCE: See Circumcision
PRESCRIPTION: See also Glasses; Medicolegal Abstracts at end of letter M
liquor, 1923, [Fishbein] ★931
warnings on labels of prescribed drugs, (Council discusses), 850
PRESERVATIVE: See Serum plasma; Spermatozoa; Tissues
PRESIDENT'S Atomic Energy Commission, 327—OS
Reorganization Act, need for clarifying lobbying provisions of, 112—OS
PRESS: See Newspapers
PREVENTIVE MEDICINE: See also Immunization; Vaccination
department aid, Ohio, 336
PRIAPISM in leukemia, dicumarol contraindicated, 73
PRIORITIES AND ALLOCATIONS: See also Automobiles
streptomycin, allocation to France, 1234
streptomycin allocation to Veterans Administration increased, 787—OS
PRISONERS of War: See World War II, prisoners
PRIVILEGED COMMUNICATIONS: See Medicolegal Abstracts at end of letter M
PRIZES: See also Fellowships; Lectures; Scholarships
Albert Medal, 878
Alvarenga, 882
American Association for Advancement of Science, 416
American Institute of Nutrition Award, 51
American Pharmaceutical Manufacturers Association award to Mayo Foundation, 337
American Women's Association Medal, 256
Awards for Distinguished War Service: See World War II, Heroes
Borden Awards, 794
Bronze Star: See World War II, Heroes
Capps (Joseph A.), 637; 1292
Crane, to discover cause and cure of poliomyelitis, [Fishbein] ★841
Doyne (R. W.) Memorial Medal, 706
Fulton County Medical Society, to encourage writing, 1227
Gibbs (Edward N.) Memorial, 415
Gibbs (Willard), 878
Hoover Medal, 185—OS
Jefferson Medical College awards to students, 562
Jeffries Award, 408
Kappa Sigma Fraternity, 51
Kober (George Martin), 1015—OS
Lasker Award of Planned Parenthood Federation, 337
Mississippi Valley Medical Society, essay contest, 191
National Safety Council traffic safety awards, 1294
National Society for Prevention of Blindness, (for paper on glaucoma) 258
Nobel, (age of winners), 296—ab (winners for 1946) 191; (Dr. Chain in Italy) 1030
Norton Medical Award, 492
Order of the Vasa (Swedish), 1230
Phi Lambda Kappa, 708
Reed (Walter) Medal, 117
Schering Award, 956

PRIZES—Continued
Sugar Research Foundation, 52
Tulsa Civil Service awards, 1164
West Virginia Cancer Society Inc., essay contest, 415
PROCAINE HYDROCHLORIDE, intravenous, for asthma, [Durleu] 729—ab
intravenous for penicillin "serum sickness" reaction, [Rosellini] 204—ab; [Dressler & Dwork] *849; (warn of danger) [Abram; Waldbott] 1301—C
sympathetic block in local shock, [Thomson] 66—ab
PROCTALGIA: See Rectum
PROCTOLOGY, interpretation of ulcerative colitis, [Kleckner] *998
PROCTOR Lecture: See Lectures
PROFESSION: See Medicine, profession of
PROFESSORS: See also Teachers
age limits, Italy, 880
retirement age (65), Buenos Aires, 196
PROGESTERONE, control of menorrhagia, [Greenblatt] 723—ab
PROMIN treatment of leprosy, 46—OS; [Wharton] 967—ab
treatment of scleroderma, [Wuerthele] 1312—ab
PROMIZOLE, treatment of leprosy, 46—OS
PROPRIETARIES, advertising, in J. A. M. A., [Fishbein] (in 1894) *390; *391; (in 1900) *534; (in 1905-1906) *681; *686; (in 1910) *764
Proprietary Association of America, enemy of A. M. A., [Fishbein] *686
PROPYL ALCOHOL: See Isopropyl Alcohol
PROPYLENE GLYCOL, for disinfecting purposes, 696—E
PROPYLTHIOURACIL, treatment in hyperthyroidism, [Astwood] 500—ab; 544—E
treatment in thyrotoxicosis, [Reveno] *1190
PROSTATE, cancer and vesical cancer, 279
cancer, estrogens for [Fergusson] 69—ab; [Weijtlandt] 503—ab
cancer, ethinyl estradiol for [McCrea] 965—ab
cancer, prostatic phosphatase in serum, [Herbert] 69—ab
cancer, skeletal metastases with myelofibrosis, [Bersack] 131—ab
hypertrophy or cancer, vasectomy to prevent, 358
Inflammation: See Prostatitis
Surgery: See Prostatectomy
PROSTATECTOMY in tenth decade, [Frater] 69—ab; [Scholtz] 503—ab
suprapubic, thrombin and fibrin foam in, [Quinby] 203—ab
PROSTATITIS treatment, streptomycin, 855—E
trichomonas, 733
PROSTHESIS: See also Limbs, Artificial
experiments and training in making, 253
PROSTIGMINE: See Neostigmine
PROSTITUTION, Army and Navy merge their drive against vice, 112—OS
PROTEIN: See also Meat
Bence-Jones, in multiple myeloma, [Bayrd & Heck] *150
biochemistry of, recent developments, Netherlands, 56
Deproteinated Pancreatic Tissue: See Pancreas
diet high in, effect on bends, chokes, etc., [Burkhardt & others] *374; *376
diet low in, for multiple myeloma, [Snapper] *157
Hydrolysates: See also Amigen
hydrolysates and dextri-maltose in peptic ulcer, [CoTui] 1312—ab
hydrolysates in myasthenia gravis, 1252
hydrolysates in peptic ulcer [Ruggiero] 272—ab
in Blood: See Blood
in Spinal Fluid: See Cerebrospinal Fluid
in Urine: See Albuminuria
nitrogen balance, 247—E
Sensitivity to: See Anaphylaxis and Allergy
PROTEOSE, urinary, treatment of allergy, [Rhoads] 135—ab
PROTEUS and paracolon cultures, urea medium to differentiate, [Christensen] 136—ab
OX strains, specificity of Weil-Felix reaction, 358
vulgaris urinary tract infection, streptomycin for, [Adcock & Plumb] *579
PROTHROMBIN: See Blood prothrombin
PRURITUS ani, neurogenic, [Granet] 126—ab
generalized, 812
relief by biliary drainage, [Varco] 1314—ab
PSEUDOGLYCOSURIA in patients given penicillin, [Holdyreff] 715—C
PSEUDOHEMOPHILIA, [Perkins] 349—ab
possible case of? 1320
PSEUDOMONAS aeruginosa urinary tract infection, streptomycin for, [Adcock & Plumb] *579
PSITTACOSIS, [Meyer & Eddie] *822; (diagnosis in children) *824
PSYCHIATRY: See also Hospitals, psychiatric; Mental Disorders; Mental Hygiene; Neuropsychiatry; Psycho—
alcohol problem and, 561
American Board of: See American
casualties (war), high incidence [Hanley] 344—C
PSYCHIATRY—Continued
clinics for children, 878
diagnosis, methedrine in, [Simon] 724—ab
graduate training, Pa., 1024
pavilion opened, N.Y.C., 637
Personnel Placement Service, 117
Psychiatric Foundation, function, 878
research, positions open, 337
sense and nonsense, [Burlingame] *971
social workers institute, 413
PSYCHIATRISTS confer at War Department, 408
National Advisory Mental Health Council advocates training 600, 405—OS
positions open, 877
PSYCHOANALYSIS, Chicago Institute for, research, 1023
PSYCHOANALYSTS, congress of, Italy, 881
PSYCHOLOGY, factors in obesity, [Freed] *369; [Johnson] 1238—C
of tuberculous, [Day] 428—ab
PSYCHONEUROSIS: See also Neurosis
treatment, electrical convulsions, [Milligan] 68—ab
PSYCHOPATHIC Hospitals: See Hospitals, psychiatric; Hospitals, state
PSYCHOSES: See Mental Disorders
PSYCHOSOMATIC disorders, ocular symptoms, [Harrington] *669
medicine, in neurology, [Wilson & Rupp] *509
PSYCHOSURGERY: See Brain surgery
PUBLIC Health: See Health
Health Nurses; Nursing: See Nurses; Nursing
relations and medical profession, [Swart] 554—ab
relations, how can local societies promote? [various authors] 628—ab
Schools: See Schools
Speaking: See Speakers
PUPILS: See Children, school
PUERPERIUM, blood picture in, 1254
complications: acute mastitis, penicillin for, [Taylor] 428—ab
early rising, [King] 129—ab
hemorrhage, (postpartum) [Odell & others] *735
infectious mononucleosis in, [Trincao] 142—ab
pituitary necrosis postpartum and diabetes insipidus, [Spain] 727—ab
PUERTO RICO, medical activities, A.M.A. resolutions on inclusion in JOURNAL, 40
PULLMAN Cars: See Railroads
PULMONARY: See Lungs
Embolism: See Embolism
Tuberculosis: See Tuberculosis of Lung
PULMONARY VALVE, gonococcic endocarditis of, penicillin for, [Myers] *1205
stenosis (congenital), surgery for, [Blalock] 426—ab
PULSE rate, effect of high altitude flight, [Behnke] *450
PURPURA, hereditary hemorrhagic thrombasthenia, [Perkins] 349—ab
thrombopenic, after rubella, [Magnusson] 968—ab
thrombopenic, BAL for, [Lockie & others] *754
PUS: See Abscess; Skin infection; Suppuration; Ulcers
PUSEY, WILLIAM ALLEN and A.M.A. Council disagreement, 1924, [Fishbein] *934
PYELOGRAPHY in hypertension; splanchnicectomy, [Nesbit] 1311—ab
PYELONEPHRITIS, treatment, streptomycin, [Adcock & Plumb] *579
PYLETHROMBOPHLEBITIS, treatment, streptomycin, [Wishart & Peterson] *539
PYOGEN, spray promoted to industry as "cold" cure (Joint Council report), 694
PYREXIA: See Fever
PYRIBENZAMINE, antihistamine drugs and hypertension, 812
histamine antagonist, [Friedlaender] 1309—ab
treatment of penicillin urticaria, [Pillsbury & others] *1255
PYRIDOXINE treatment of myasthenia gravis, 1252
PYROSIS: See Heartburn

Q

Q FEVER in U. S., [Topping & others] *813; [Irons & Hooper] *815; [Irons & others] *819; [Cox & others] *820
QUARTERLY Cumulative Index Medicus: See American Medical Association
QUESTIONNAIRES, A.M.A. Committee on National Emergency Service to civilian physicians, 480—E; [Dickinson] 548—ab; 550—ab
A.M.A. Committee on Rural Medical Service, 941—OS
QUINACRINE HYDROCHLORIDE (atabrine)
blood plasma concentrations, [Becker] 202—ab
"blue halos" of cornea in atabrine workers, [Mann] 1315—ab
fluorescence of nails, 1252
suppression of malaria, individual failures, [Bang] 132—ab
toxicity: dermatitis and aplastic anemia, [Drake] 134—ab
QUINACRINE HYDROCHLORIDE—Continued
toxicity: dermatosis, [Peterkin] 727—ab
treatment of Giardia lamblia infection, 74
QUINIDINE, dosage schedule, 1044
sulfate and lanatoside C for auricular flutter, [Tandowsky] 424—ab
sulfate, treatment of acute coronary occlusion, 357
QUININE and plasmochin combined for vivax malaria, [Most] 570—ab
anticipating need for, by A. M. A. in 1870 [Fishbein] *101
poisoning, value of gastric lavage in, 545—E; (technic) [Kantor] 1238—C
Quinine-Dextro, 568—BI
QUINSY Sore Throat: See Abscess, peritonsillar

R

RABBIT Fever: See Tularemia
RABIES, [Meyer & Eddie] *822
vaccination required for all dogs, N. Y. C., 116
vaccine, complication, [Zabludovich] 430—ab
vaccine, myelitis after, [Bussell] 728—ab
warning, Chicago, 561
RACES: See also Indidans; Negroes
specific disease: sickle cell anemia, 33—E
RADIANT energy lamps, Eastman, 1008
RADIATION: See also Atomic Energy; Infra-Red Rays; Radiotherapy; Radium; Roentgen Rays; Ultraviolet Rays
Therapy: See also Radiotherapy; under names of specific organs and diseases
therapy in breast cancer, [Kaplan] 1245—ab
therapy, mechanism of effects, [Warren] *462
RADICULITIS: See Sciatica
RADIO: See also Television
dramatization by CBS: "A Long Life and a Merry One" reviewed, 1161—OS
dramatizations, costs to state societies, [various authors] 630—ab
electrical transcriptions: "Medicine serves America," 324—E; 326
Frequency Energy Apparatus: See Diathermy
Program by A. M. A.: See American Medical Association
state society participation in network broadcasts, [Bauer] 548—ab
RADIOACTIVE drugs, tests at National Cancer Institute, 631—OS
Elements: See Atomic Energy
Iodine: See Iodine
Phosphorus: See Phosphorus
RADIOLOGY, American College of, graduate course in, 337
Indian Journal of Radiology, new journal, 416
RADIOPHOSPHORUS: See Phosphorus
RADIOTHERAPY: High Dosage Treatment (motion picture review), 802
RADIUM, Belgium gift to Switzerland, 118
Emanation: See Radon
poisoning, determine radium in body to prevent, [Hess] 1305—ab
treatment, local recurrence of cancer 18 years after, [Covington] *935
RADON nasopharyngeal applicator for asthma in children, [Ward & others] *1060
needles (interstitial), comparative value, [Taylor] 130—ab
RAGWEED dermatitis, [Slater] 803—ab
control, N. Y. C., 1228
RAILROADS, Pullman car sanitation, Dr. Hurty urges A. M. A. action in 1901, [Fishbein] *607
RAINIER Natural Soap, 568—BI
RAMALINA reticulata, Spanish moss as antibiotic, [Marshak] 1245—ab
RAMSES Vaginal Jelly; also Applicator, N.N.R., (Schmid) 1281
RASH: See Eruptions
RATION: Rationing: See Food; Priorities and Allocation
RATS: See also Rodents
control program, Cleveland, 1024
reproduction of, given caffeine, [Bachmann] 202—ab
RAYNAUD'S DISEASE, ocular symptoms, [Harrington] *672
RAYS: See Radiation
RAZ-MAH, Templeton's, Capsules, 568—BI
REBATES and fee splitting, [Patek] 715—C; (A. M. A. action in 1924) [Fishbein] *933
RECEPTOR gradient (virus) in erythrocytes, [Burnet] 67—ab
RECORD Librarians: See Medical Record Librarians
RECREATION: See also Physicians, avocations
Recreational and Occupational Therapy, (motion picture review), 802
RECRUITS: See also World War II
physical examinations of, in final months of war, 854—E
RECTOSIGMOID, cancer [Howard] 427—ab
RECTUM: See also Anus; Proctology
cancer, [Howard] 427—ab
cancer, conservative operation, 55
cancer, contact roentgen therapy, [Gros] 651—ab

133
947

RECTUM—Continued
cancer, surgical cure, preserve anal sphincter function, [d'Allaines] 729—ab
hemorrhage, rutin and sulfonamides incompatible [Kushlan] 716—C
hemorrhage, rutin therapy of telangiectasia, 247—E
pain, proctalgias [Granet] 127—ab
Suppositories: See Suppositories
surgery, new hemostatic dressings for, [Rosser] 893—ab
RECUMBENCY, Early rising After Operation, etc.: See Convalescence
RECURRENT Fever: See Relapsing Fever
RED CELLS: See Erythrocytes
RED CROSS, Swedish, home for tuberculous children, 712
Swiss, chief resigns, 878
RED CROSS, AMERICAN, in 1922, [Fishbein] *929
blood bank program, 415; 945—OS
blood donor service (new), N. Y., 955
drive for funds, 638
health education by, 1289
Senate gives chapters greater voice in affairs, 788—OS
spends $730,000,000 in 7 years, 327—OS
surplus plasma distributed by, 482—OS
REDUCING Treatment: See Obesity
REED, C. A. L., resigns from A. M. A. Committee on Medical Legislation, [Fishbein] *763
REED (Walter) Medal: See Prizes
REFLEX, Carotid Sinus: See Carotid Sinus syncope
conditioned, aversion treatment of alcoholism, [Shanahan] 135—ab
conditioned, Pavlov's studies, 713
REFRIGERATION Anesthesia: See Anesthesia surgical, and tissue preservation [Crossman & Allen] *377; [Pernworth] 1308—ab
REGISTER: Registry: See Cancer; Chorionic Carcinoma; Tuberculosis
REHABILITATION, after chest surgery, 1029
aural, center opened, Washington, D. C., 408
hearing and speech, program, Ill., 561
hospital for spastic children, 256
Institute of, campaign to raise $2,000,000, 50
National Council on, 708
of patients with injury to spinal cord (motion picture review), 1033
vocational, in Illinois, [Pearson] 501—ab
Vocational Rehabilitation Act, additional training under, 113
REITER'S SYNDROME and pleuropneumonia-like organisms, [Wallerstein] 137—ab
RELAPSING FEVER, louse borne, penicillin for [Ingraham] 207—ab
RELEASE of Medical Officers: See World War II, medical officers
RENAL: See Kidneys
Glycosuria: See Glycosuria
Rickets: See Osteodystrophy, renal
RENDU-Osler-Weber Disease: See Telangiectasia
RENIN in cardiac failure, [Merrill] 424—ab
in essential hypertension, [Taquini] 61—ab
REPRODUCTION: See also Contraception; Fertility; Pregnancy; Sterility
of rats given caffeine, [Bachmann] 202—ab
RESEARCH: See also Animal Experimentation; Science; under specific headings as Cancer
approach to, 366—ab
center (medical) U.S.P.H.S. seeks, 45—OS
clinical, cost, Therapeutic Trials Committee report, *30
ethical, Western Society for, organized, 336
continued need for, 184—OS
defense, in 1900, [Fishbein] *533
Fellowships: See Fellowships
Grant for: See also Foundations
grant in endocrinology by National Research Council, 118
grants for, by National Advisory Health Council, 1289
Institute for Tropical Medicine, Liberia, 192
medical, A. M. A. Council on Defense of, [Fishbein] *691; *763
medical, Childs Memorial Fund for, 1231
medical, Committee on, of OSRD, accumulated records, 1293
medical, German, unpublished, 416
medical, long range program by National Research Council, 1289
medical, nationwide, organization for, 187
medical, Oklahoma Foundation, 414
medical progress and, 400—E
Medical Research Council: See Medical Research Council
National Research Council: See National Research Council
needs in nutrition, [Jeans] *245
nuclear, for medical and public health work, 327—OS
prisoners act as guinea pigs in German camps, Dr. Ivy's report, 35; [Wertham] 645—C
Prizes for: See Prizes
program of U. S. government, 462—ab
Scandinavian cooperation in, 421
science and U. S. government, stable relations reported by Dr. Bush, 250—OS
RESEARCH—Continued
Seaman Fund for, in bacteriology and sanitary science, 415
wartime, Truman thanks scientists for, 327—OS
RESIDENTS AND RESIDENCIES: See also Fellowships; Interns and Internships
additional, approved by A. M. A., *1078
in federal hospitals, *1080
in hospitals, 944—OS; *1078
in specialties, evaluation, cooperation of specialty boards, *1081
in veterans hospitals; work by medical schools, 855—E; (round table discussion) [various authors] 856—ab; *1081
9-9-9 Program: See Interns and Internships
opportunities, statement by Dr. Johnson (Joint Committee report), 41
program for physician veterans (Joint Committee report), 42
training, facilities for, *1080
training in applied basic medical sciences, 697—E; 717
training in neurology, 186
RESORCINOL: See Hexylresorcinol
RESORTS: See Health resorts
RESPIRATION, anoxia and, in aviators, [Behnke] *453
Artificial: See Respirator
breathing exercise, rehabilitation after chest surgery, 1029
Disorders: See Asphyxia
hyperventilation to induce migraine, (reply) [Foldes] 280
intrauterine, of fetus, [Windle & Becker] 125—C
liquid oxygen converter for breathing purposes, 559
pulmonary ventilation vs. carbon monoxide in high altitude flight, [Behnke] *454
sounds, phonograph recordings, [Stokes] 429—ab
spirometry in Besnier-Boeck-Schaumann's disease, [Leitner] 730—ab
RESPIRATOR, A. M. A. Council refuses to recognize term "iron lung," 936
RESPIRATORY METABOLISM: See Metabolism, basal
RESPIRATORY SYSTEM: See also Bronchus; Lungs; Pleura; Trachea
Disease: See also Bronchiectasis; Lungs; Pneumonoconiosis
disease, streptococcus and nonstreptococcic, [Rantz] 132—ab
disease (acute), Commission on, tonsillitis and pharyngitis of unknown cause, *588
Infection: See Colds; Influenza; Pneumonia; Tuberculosis of Lungs
tumor cells spread via, [Furth] 268—ab
REST: See Sleep
Bed, early rising after operation, etc.: See Convalescence
RESTAURANTS, drive to clean up, Chicago, 255; 875
health department closes five, N. Y., 1229
RETAIL trading areas, principles applied to study of medical service, 1011—E; [Dickinson] *1041
RETINA: See also Retinitis
central angiospastic retinopathy; psychosomatic disorders, [Harrington] *672
stimuli, motor component, 713
RETINITIS pigmentosa, tissue therapy, [Liphina] 652—ab
RETINOBLASTOMA, heredity; evidence in 2 families, [Falls] *171
RETIREMENT: See Army, U. S.; Professors
RETROBULBAR Neuritis: See Nerves, optic
REVISTA: See Journals
REYBURN, ROBERT, case history of President Garfield, [Fishbein] *389; *390
RH Factor, 577
blood laboratory set up, Washington, D. C., 184—OS
blood typing, Conn., 636
federal biologics regulations revised and expanded, 855—E
in newborn and erythroblastosis, [Hill] 201—ab
interaction of spinal fluid and, [Jakobowicz] 805—ab
isoimmunization, [Philpott] 1035—ab
RHEUMATIC FEVER, acute, salicylates effect on, [Warren] 1—ab
Cardiac Complications: See Heart disease (rheumatic)
diagnosis, criteria, [Griffith] *974; (in young adults) [Sokolow & Snell] *981
diagnostic centers, Mich., 335
frequency, [Harving] 806—ab
Herrick House for convalescent children, Ill., 636
Institute for Study of, at Northwestern U., 791
treatment: salicylates, oxygen, diuretics, sulfonamides, penicillin, vitamins, iron, fever, roentgen therapy, blood plasma, serums and vaccines, climatotherapy and physiotherapy, [Griffith] *974
RHEUMATISM: See also Arthritis
Acute Articular: See Rheumatic Fever
chronic, copper salts in, [Forestier] 1317—ab
RHEUMATISM—Continued
Desert: See Coccidioidomycosis
Empire Rheumatism Council, (10th anniversary) 52; (study cause of rheumatoid arthritis) 341
facial paralysis, [Bergstrom] 1318—ab
treatment, penicillin, France, 55
Trubek fellowship in rheumatic disorders, N. Y., 49
RHEUMATOID Arthritis: See Arthritis
Spondylitis: See Spine
RHINITIS, Vasomotor: See Hay Fever
RHINOPHARYNX: See Nasopharynx
RHINOSCLEROMA, [Reves] 269—ab
RHUS dermatitis, [Turner] 1304—ab
RIB: See Ribs
RIBOFLAVIN: See also Pellagra
allergy, 434
N.N.R., (Harrower) 619
RIBS, fracture, pneumonia after, [Phillips] *161
RICH Report, question of publication (Reference Committee report), 38
RICKETS, Renal: See Osteodystrophy, renal
RICKETTS, HOWARD TAYLOR, death, 1910, [Fishbein] *764
RICKETTSIA: See also Q Fever; Rocky Mountain Spotted Fever; Typhus
Disease (New): See Rickettsialpox
disease, specificity of Weil-Felix reaction, 358
RICKETTSIALPOX [Huebner] 272—ab; [Greenberg & others] *901; (correction) 1231
RIEDEL'S Lobe: See Liver
RIGGS Foundation: See Foundations
RIMOLDI, HORACIO J. A., to study in U. S., 258
RINGWORM of Scalp: See Tinea capitis
RISING, Early, after Operation, etc.: See Convalescence
RIVERS, water pollution control bill, 1219—OS
water pollution, construct plant to eliminate, Illinois, 1292
ROCKEFELLER Foundation: See Foundations
ROCKET, insects survive flight into ionosphere by, 874—OS
ROCKY MOUNTAIN SPOTTED FEVER, diagnosis (differential) from rickettsialpox, [Greenberg & others] *904
grant to study tick fever, 1291
treatment, p-aminobenzoic acid, [Ravenel] *983
RODENTS: See also Mice; Rats
poliomyelitis transmitted to, 1217—E
war on, continuation, 871—OS
RODMAN, W. L., National Board of Medical Examiners, 1915, [Fishbein] *837; *839
ROENTGEN RAYS apparatus (portable), sale of, 559
bone age studies and hypothyroidism, [Dutton] 965—ab
burns, sulfhydryl treatment, [Cruthirds] 131—ab
Diagnosis: See also Roentgenography (cross reference)
diagnosis in tuberculosis, compare photofluorographic and other methods, [Birkelo & others] *359; 399—E; [Kovnat] 963—C
diagnosis, stereoroentgenograms in esophageal leiomyoma, [Schafer & Kittle] *1202
Irradiation: See Roentgen Therapy
pharmacoradiographic agent: insulin, 420
technicians, schools for, approved by A.M.A., *1144
technicians, statistics on in hospitals, *1077
ROENTGEN THERAPY: See also Bursitis; Hemophilia; Spine arthritis
contact, in rectal cancer, [Gros] 651—ab
deep, centers for, by Army Medical Department, 329
in pregnancy cause congenital malformations, [Keitel] 716—C
intravaginal cones for [Taylor] 130—ab
ionization measurements with bone chambers, [Stenstrom] 887—ab
near distance, Chaoul's modified method, [Arho] 142—ab
ROENTGENOGRAPHY: See Arteries, roentgen study; Gallbladder, roentgen study; Lungs, roentgen study; Peptic Ulcer diagnosis; Pyelography; Roentgen Rays diagnosis
RONGETTI, AMANTE, sentenced for practicing without license, 1023
ROSENBERGER, J. L., abstracts of medicolegal decisions, 1893, [Fishbein] *389
ROSENSTOCK Foundation: See Foundations
ROTHSCHILD Lecture: See Lectures
ROULEAUX Formation: See Erythrocytes
ROUNDWORMS: See Ascaris; Ascariasis
ROVIN, ALEXANDER M., interest in pyogen, (Joint Council report) 604
ROVSING'S Sign, rebound tenderness in abdominal disease, 508
ROYAL: See also British; England
College of Nursing, 1029
College of Surgeons, (overseas examinations for fellowship) 121; (report) 261; (conflict on National Health Service Act) 419; 643
Colleges (controversy on National Health Service, England) 419; 643
RUBBER balloon, dermatitis due to, 1174
gloves, dusting powders for, 1218—E
gloves, talc granuloma, [Lichtman] 206—ab

RUBBER—Continued
manufacture, prevent dermatitis in, 1254
tires filled with water, mosquitoes transported in, 559; [Pratt] 725—ab
RUBELLA, maternal, cause of deaf-mutism in child, 1012—E
maternal; congenital deafness in child, [Hopkins] 268—ab; [Clayton-Jones] 1316—ab
maternal; defects in child, [Swan] 1316—ab
thrombocytopenic purpura after, [Magnusson] 968—ab
RUBEOLA: See Measles
RUBINOW, I. M., A. M. A. committee report on social insurance [Fishbein] *836 ff., *923
RUFUS, HOWARD C., personal, 469
RUPTURE: See Hernia; under name of organ as Kidneys; Spine, intervertebral disk; Spleen
RURAL COMMUNITIES: See also Farmers
health centers and hospital facilities for, [Weagley] 781—ab; [Davis] 860—ab; (Committee report) 860—ab
health, Committee on Health Council as Agency for Promoting, [Jones] 864—ab
health, National Conference on, (program) 326—OS; (proceedings) 778—OS; 860—OS
health problems, Turkey, 1236
health, survey, Conn., 636
medical facilities available, Virginia, 251—OS
medical prepayment plans as they apply to, [Mertz] 782—ab
medical prepayment plans, experience with Blue Cross, [Helsby] 407
medical service, A. M. A. Committee on, (report) 37; (questionnaire) 941—OS; 945—OS
medical service program and the farmer, [Goss] 778—ab
medical service (Joint Committee report), 44
medical service, (Reference Committee report), 37
nursing needs, committee report, [Sewell] 863—ab
physicians for, methods of bringing and holding, [Humphrey] 778—ab; [Starr] 779—ab; [Mulholland] 861—ab
physicians for, scholarships to provide, (Indiana) 489; (Illinois) 709
RUSH, BENJAMIN, monument, [Fishbein] *311; *315; *316; *468; *469; *613; *682
RUSSIA, cancer treatments from, 111—E; 122; [Gross] 800—C; [Klyuyeva] 1038—ab
foreign letter from, 122; 713; 1235
training 1,980,000 technicians in 5 years, 788—OS
visiting scientist returns to Moscow: V. V. Parin, 638
visitors (physicians) to India, 1235
visitors to Stockholm, 421
RUTIN, incompatible with sulfonamides, [Kushlan] 716—C
treatment of hereditary hemorrhagic telangiectasia, 247—E

S

S-140: See Demerol
S. 140: See Taft-Fulbright Bill
S. 1606: See Wagner-Murray-Dingell Bill
SACRAL CANAL, Injection Into: See Anesthesia, caudal
SADDLE Block: See Anesthesia
SAFETY: See also National Safety Council
code (new) for anesthesia apparatus, England, 797
ST. JOHN'S bread (powdered) treatment of diarrhea, [Rohmer] 729—ab
SALARIES: See Income; Wages
SALESMEN, Fraudulent: See Impostors
SALICYLATES: See also Acid, acetylsalicylic
effect on acute rheumatic fever, [Warren] 61—ab
SALIVA, sialorrhea and morphine addiction, 899
SALT: See also Sodium chloride
deficiency in sprue, [Black] 352—ab
diet low, in congestive heart failure, [Wheeler & others] *16; (early work of Hermann Strauss in 1902), [Gossels] 497—C
iodized, and goiter; amend Food, Drug and Cosmetic Act; A. M. A. Council decision, 620—E
iodized, federal law proposed, 1161
mobilization of salts from skeleton; lability of bone, 110—E
water metabolism, disturbance in hypertension, [Perera] 499—ab
SAN JOAQUIN Valley Fever: See Coccidioidomycosis
SANITATION: See also Health; Hygiene
Industrial: See Industrial Hygiene
lacking in restaurants, (Chicago) 255; 875; (New York) 1229
SANO, 568—BI
SARCOIDOSIS, electrocardiographic and spirometric study, [Leitner] 730—ab
simulating glomerulonephritis, [Klinefelter] 722—ab
symptom of tuberculosis, [Cameron] 207—ab
uterine changes in, [Engelhard] 70—ab
SARCOMA: See under organ or region affected as Bones; Breast; Uvea
SARDINES, embargoed, food poisoning from, 50; 817
SAVINGS: See Investments
SCALDS: See Burns
SCALENOTOMY: See Muscles
SCALENUS Anticus Syndrome: See Muscles
SCALP: See also Alopecia; Hair; Head
Dr. Marshall's Medications, 568—BI
Ringworm of: See Tinea Capitis
SCANDINAVIAN cooperation in research, 421
SCAPULA: See Shoulder
SCAR: See Cicatrix
SCARLET FEVER, treatment, penicillin, [Jennings] 1303—ab
treatment, penicillin effect on evolution of, 960
treatment, penicillin to prevent acute otitis media, [Weiss] 206—ab
treatment, penicillin, vs. antitoxin and symptomatic therapy, [Hirsh & others] *657
treatment, penicillin, vs. convalescent serum and sulfonamides, [Hoyne & Brown] *661
when to discharge patients, Denmark, 961
SCHAFFNER'S "Little Doc" Jr. First Aid Kit, 883—BI
SCHAUMANN-Besnier-Boeck Disease: See Sarcoidosis
SCHERING Award: See Prizes
Corporation, government profits from, 556—OS
SCHISTOSOMIASIS, Asiatic, [Warren] 1311—ab
Asiatic, latent phase, [Mason] 888—ab
diagnosis, cercarial antigens for intradermal test, [Alves] 69—ab
japonica in Leyte occupation, fuadin for, [Winkenwerder] 1242—ab
SCHIZOPHRENIA: See Dementia Precox
SCHIZOTRYPANUM cruzi: See Trypanosoma cruzi
SCHOLARSHIPS: See also Fellowships
established, Ky., 189
for study of eye diseases, N. Y., 50; 637
National Society for Prevention of Blindness, 794
regional, at Washington, 413
to provide rural physicians, (Ind.) 489; (Ill.) 706
SCHOOLS: See also Education; Students; University
Children: See Children, school
for food handlers, Ga., 489
for Medical Record Librarians: See Medical Record Librarians
for Technicians: See Occupational Therapy; Physical Therapy; Roentgen Rays; Technologists
health and physical fitness project of A. M. A., 945—OS
health challenge of our schools, 696—E
health education, W. Va., 491
health program, body measurements, [Stuart] 718—ab
health program, Fla., 561
hygiene, congress of, France, 52; 118
National School Health Services Act, 632—OS
of Nursing: See Nursing
Summer School of Alcohol Studies at Yale, 636
Teachers: See Teachers
SCHOOLS, MEDICAL: See also Education, Medical; Students, Medical; University; under names of specific schools
Association of American Medical Colleges, (survey by) 109—E; 945—OS; (plan for uniform intern placement) 267
Curriculum: See Education, Medical
deans' committees, residencies in veterans hospitals, 855—E; (round table discussion), 856—ab
deanships, unprecedented turnover in, 492
financing, 1158—E
graduate, of College of Medical Evangelists, 115
in Spain, 343
new, founding, [Weiskotten] *1045
new undergraduate, proposed, Palestine, 416
rating by A. M. A., 1910, [Fishbein] *763
responsibilities to a community, [Greene] *1053
statewide committee on behalf of, [various authors] 629—ab
survey, 109—E; 945—OS
U. S. Army Medical Department Research and Graduate School, 789
U. S. Navy School of Aviation Medicine and Research, 488
U. S. Navy School of Tropical Medicine, new, Guam, 331
SCIATICA, acute rheumatic, stretching sciatic nerve in, [Cammaert] 968—ab
herniated disk and, [Thiebaut] 430—ab
SCIENCE: See Journals
SCIENCE: See also Research
Basic: See Basic Science
board (presidential), Powers named to presidential scientific board, 185—OS
Medical: See Medicine
National Science Foundation, 180—E; 184—E; 328—OS; 1161
UNESCO, Paris conference, 342
SCIENTIFIC Exhibit: See American Medical Association
Tests: See Medicolegal Abstracts at end of letter M
SCIENTISTS, Truman thanks, for wartime research, 327—OS
SCLERODERMA, treatment, 578
treatment, promin, [Wuerthele] 1312—ab
SCLEROMA: See Rhinoscleroma
SCLEROSIS: See also Arteriosclerosis; Blood Vessels; Liver cirrhosis; Otosclerosis
multiple, Association for Advancement of Research in, 878
multiple, dicumarol for, [Putnam] 1306—ab
multiple, what do we know of? [Reese] 201—ab
SCOTOMA, angioscotoma in prolonged mild anoxia, [Smith] 1308—ab
SCROTUM Hernia: See Hernia
SCRUB Typhus: See Tsutsugamushi Disease
SCURVY, anemia in, [Wade] 64—ab
vertigo and, [Ohnell] 430—ab
treatment, vitamin C, [Schnurrum] 1036—ab
SEA Vegecene, 883—BI
Vegetable Tablets, West's Imported, 883—BI
Vegetables Vitaminized with Added Vitamin A, 883—BI
SEASICKNESS: See Motion Sickness
SEALS, A. M. A., use of, 112—OS; 321
SEAMAN Fund: See Foundations
SEA-Sol, 883—BI
SEA-V-Ald, 883—BI
SEA-Vo-Kra, 883—BI
SEBACEOUS Cyst: See Steatoma
SEBORRHEA and pilocarpine, 577
SECONAL sodium, convulsive seizures after barbiturate withdrawal, [Osgood] *104
SECRETARIES: See Societies, Medical
SECURITIES: See Investments
SECURITY: See Social Security
U. S. Department of: See Taft-Fulbright Bill
SEDATIVES and postoperative vomiting, 810
SEDIMENTATION Rate: See Blood
SEEING-eye Dogs: See Dogs
SEIZURES: See Convulsions; Epilepsy
SELECTIVE SERVICE: See World War II; Medicolegal Abstracts at end of letter M
SELF-MEDICATION: See also Nostrums
of benadryl, danger, [Borman] *394
SEMEN: See Spermatozoa
Artificial Insemination: See Impregnation, artificial
SEMICARBAZONE, 5-nitro-2-furaldehyde, use in dermatology, [Downing & others] *299
SEMINOMA: See Dysgerminoma
SENILITY: See Old Age
SENSATION: See Paresthesia
SENSES: See Hearing; Taste; Vision; etc.
SENSITIVITY: Sensitization: See Anaphylaxis and Allergy
SEPTICEMIA: See Meningococcemia
SERODIAGNOSIS: See Syphilis; Trichinosis; Typhus
SERUM: See also Biologic Products; Vaccine
Antireticular Cytotoxic: See Bogomolets
Blood: See also Serum, plasma; etc. and subheads under Blood
blood, where obtain antiserum for measuring antibodies in? 810
Convalescent: See Scarlet Fever
plasma (human), (Council discusses), 850
plasma (human), storage in liquid state, [Lozner] 349—ab
plasma (surplus), distribution by American Red Cross, 482—OS
plasma, toxicity of phenyl-mercuric borate used to preserve? 214
Plasma, Transfusion of: See Blood Transfusion
plasma, treatment of epidemic keratoconjunctivitis and keratitis, 508
Reaction: See Anaphylaxis and Allergy
regulations, revision and expansion of, 855—E
Sickness: See Anaphylaxis and Allergy
SERVICE, Physicians Separated from the Service: See World War II, Medical Officers
SERVICEMEN: See Veterans; World War II Readjustment Act; See G. I. Bill of Rights
SEWAGE system, new (2), Ill., 954
pollution of rivers, bill to control, 1219—OS
SEX: See also Fertility; Reproduction; Sterility
Desire: See Libido
Function, Decline of: See Menopause
function in men, prolonged use of barbiturates affect? 279
Hormones: See Androgens; Estrogenic Substances; Gonadotropins
importance of donors and recipients in transfusion, [Hustin] 1038—ab
Impotence: See Impotence
Intercourse: See Coitus
National Research Council Committee for Research in Problems of, 492
Offenses: See Prostitution
Organs: See Genitals
SEXUAL STERILIZATION: See Sterilization, Sexual
SHELLFISH: See Clams
SHERMAN Antitrust Act violation by trade in surgical dressings, 52
SHINGLES: See Herpes zoster
SHIPS: See also Navy
gastroenteritis aboard, 777—E
liberty ship named in honor of Sir Frederick Banting, 1294
motion sickness, mechanism, [Morton] 1306—ab
transportation of mosquitoes in old tires filled with water, [Pratt] 725—ab
SHOCK, Allergic: See Anaphylaxis and Allergy
burn, inject isotonic salt solution for, [Berman] 348—ab
Electric: See Electric shock

SHOCK—Continued
Insulin: See Insulin
local, sympathetic procaine block for, [Thomson] 66—ab
Therapeutic: See Electric shock: Insulin shock
traumatic, vitamin C in, [Holmes] 649—ab
traumatic: wound, [Stewart] ★216
treatment of curare and its substitute, bebeerine dimethylether methochloride, 882
Wound: See Shock, traumatic
SHORT WAVE: See Diathermy
SHOULDER: See also Clavicle
bursitis, roentgen therapy, [Young] 500—ab
bursitis, subacromial [Olin] 1245—ab
lesions of musculotendinous cuff, [Gunning] 429—ab
SHOVELER'S disease, [Wetzel] 652—ab
SIALORRHEA: See Saliva
SICK: See Patients
Headache: See Migraine
SICKLEMIA: See Anemia, sickle cell
SICKNESS: See Disease; Health; Therapeutics
Convalescence from: See Convalescence
Insurance: See Insurance, sickness
Rate of: See Vital Statistics
Serum: See Anaphylaxis and Allergy
SIGHT: See Vision
SILICOSIS: See Pneumonoconiosis
SILVER nitrate to prevent blindness, A.M.A. propaganda for, 1908, [Fishbein] ★689
Star: See World War II, Heroes
SIMMONS, GEORGE H., [Fishbein] (permanent secretary, 1895-1899) ★391; ★464; (employed as Journal editor and secretary, 1898) ★472; ★473; (history of A.M.A. 1902-1904) ★605; (publication of A.M.A. directory; tribute to) ★682; ★685; ★687; (reply to attack on A.M.A.) ★686; (tribute to his honesty and integrity) ★688; ★689; (secretaryship report) ★762; (attacks centered on, in 1910) ★762; (resignation, 1923) ★930; (retirement, 1924) ★932
SIMS, J. MARION, address, 1876, [Fishbein] ★175
SINGULTUS: See Hiccup
SINUS, Pilonidal: See Pilonidal Sinus
SINUSITIS, NASAL, Trapper's Preparation for Sinus, 264—BI
treatment, (modern), [Hunnicutt] ★84
SITTING posture, peroneal palsy from crossing legs, [Nagler & Rangell] ★755
SKELETON: See Bones
SKIN: See also Dermatology; Tissues
Burn: See Burns
cancer, near distance roentgen therapy (Chaoul's), [Arho] 142—ab
Cleansing: See Detergents; Soap
diphtheria, [Livingood] 892—ab
Disease: See also Acne; Dermatitis; Scleroderma; Skin infection; Urticaria
disease, furacin for, [Downing & others] ★299; [Morin] 963—C
Disease (Industrial): See Industrial Dermatoses
disease, penicillin ointment for, [Wright] 1305—ab
Eruptions: See Eruptions
Exfoliation: See Dermatitis exfoliativa
graft (composite free) [Brown] 720—ab
graft (full thickness) to repair urethra in hypospadias, 970
graft, implant cadaver skin plus aloe in retinitis, [Lipkins] 652—ab
graft, thickness, [Padgett] 268—ab
Hemorrhage: See Purpura
infants, anergy to diphtheria, [Wright] 573—ab
Infection: See also Carbuncle; Furunculosis
infection, neurologic disease after, [Bronson] 500—ab
infection (pustular), prevention in newborn, [Weymuller & others] ★81
infection (pyogenic), penicillin for, [Hopkins] 886—ab
Inflammation: See Dermatitis
Itching: See Eczema; Pruritus
Leishmaniasis: See Leishmaniasis
Peeling: See Dermatitis exfoliativa
Rash: See Eruptions
Reaction: See also Anaphylaxis and Allergy; Skin test; Tissues reaction; Tuberculin; Urticaria
reaction to BCG cultures, [Civeira] 503—ab
test reagent for whooping cough standardized, [Felton] 892—ab
tests in trichinosis, [Roth] 968—ab
Transplantation: See Skin graft
Ulcers: See Ulcers
SKULL: See Cranium
SKYSCRAPERS: See Buildings
SLAUGHTER house, Q fever in U. S., [Topping & others] ★813; [Irons & Hooper] ★815; [Irons & others] ★819; [Cox & others] ★820
SLEEP, hypnagogic hallucinations in drowsy period before, 1253
Induced: See Anesthesia
producing drugs, U. S. officials puzzled by large consumption, 405—OS
prolonged, induced in treatment of pain, [Kaminski] 431—ab
SLEEPING Sickness: See Encephalitis, Epidemic
SMALLPOX, diagnosis (differential) from rickettsialpox, [Greenberg & others] ★904
SMALLPOX—Continued
epidemic, Rangoon, 878
incidence, U. S., 191
mortality, 2 deaths, N. Y., 1228
Vaccination: See also Vaccinia
vaccination certificates, requirements for Philippines, 709
vaccinations (1,646 successful) on troop ship, 183—E
SMEAR: See Vagina
SMELL: See Odor
SMITH, MORRIS K., personal, 790
SMITH Lecture: See Lectures
SMITH-Taft-Ball Donnell Bill: See Taft
SMOKE, dust, and sunshine, Chicago, 334
SMOKING: See Tobacco
SNIJDERS, E. P., retires, Netherlands, 712
SNYDER, L. H., prevention of genetic disease, 547—E
SOAP: See also Detergents
Medrex, 422—BI
Ranier Natural, 568—BI
sensitivity in eczema, [Beek] 895—ab
shortage, Netherlands, 713
SOCIAL Insurance: See Insurance
Medicine: See Socialized Medicine (cross reference)
Security: See also Insurance, sickness; Medical Service Plans; Security (cross reference)
security and state associations, [various authors] 551—ab
Security Fund, old age insurance, National Council of Order of Doctors, France, 1234
security, recommend, Puerto Rico, 1230
security stressed in economic report, 184—OS
security, U. S. Dept. of Welfare to handle, 180—E; 184—OS
Security, Wagner-Murray-Dingell Bill: See Wagner
welfare, Senator Robert Taft asks billion dollar budget for, 947—OS
work convention held in San Juan, 1230
Worker: See also Psychiatry
worker and long term illness, [Bluestone] ★1051
SOCIALIST Medical Association, England, 495
SOCIALIZED Medicine: See Hospitals, expense insurance; Insurance, sickness; Insurance, social; Medical Service Plans; Medicine, state
SOCIETIES, MEDICAL: See also American Medical Association; under names of specific societies; list of Societies at end of letter S
Airborne Medical Society organized, England, 261
Annual Conference of Secretaries and Editors (proceedings) 548—OS; 623—OS
county, [Meadors] 552—ab
county and state, secretaries, could A.M.A. publish list of annually, 630—OS
county and state technic to interest physician in, [various authors] 629—ab
county, Dallas, nontechnical education program, 1229
county, history of, Alameda, Calif., 1022
county, Medical Society of County of Kings 125th year, 335
county, resolution of policies on Blessing Hospital, Quincy, Ill. 489
in Soviet Union, 122
New York Academy, centennial, 190; 335
Northern Medical Association centennial, 257
Plans for Medical Service: See Medical Service Plans
Sociedad de Gastroenterologia y Nutricion, 343
Sociedad Ycateca de Obstetricia y Ginecologia, Mexico, 118
Society for Vascular Surgery organized, 257
Society of General Physicians organized, 491
State: See also Medical Service Plans
state and county, how to promote public relations, [Various authors] 628—ab
state, costs of A.M.A. radio dramatizations to, [various authors] 630—ab
state, function, [Sensenich] 548—ab
state, history of journals, [Fishbein] ★690
state, home office, [Graham] 623—ab
state, newspaper advertising and, [various authors] 628—ab
state, participation in radio network broadcasts, [Bauer] 548—ab
state, secretaries-editors conference, Pa., 1943
state, social security and income taxes, [various authors] 551—ab; [McDavitt & others] 627—ab
state, state government and, [Barker] 549—ab
state, West Virginia lifetime memberships, 491
too many in 1888, [Fishbein] ★316
Woman's Auxiliary: See Woman's Auxiliary
SODA, Baking: See Sodium bicarbonate
SODEOM, 883—BI
SODIUM Allyl (Methylpropyl Carbonyl) Barbiturate: See Seconal sodium
Amytal: See Amytal
ascorbate, 1 (—) histidine monohydrochloride, inject for peripheral vascular disorders, [Wirtschafter & Widmann] ★604
ascorbate, solution, N.N.R., (Rorer) 1009
bicarbonate, renal regulation of acid-base balance, 777—E
Chloride: See also Salt
chloride, excretion in urine, 146
chloride-glycerin-acetic acid mixture for chemical debridement of burns, 811
SODIUM—Continued
chloride, isotonic solution in burn shock, [Berman] 348—ab
p,p'-Diaminodiphenyl-n,n'Didextrose Sulfonate: See Promin
diet low in, in congestive heart failure, [Wheeler & others] ★16; (early work of Hermann Strauss in 1902) [Gossels] 497—C
fluoride, topical, in dental caries, [Knutson] 573—ab
Heparin: See Heparin
Nicotinate: See Acid, nicotinic
Penicillin: See Penicillin
Pentothal: See Pentothal
tetrathionate, in thromboangiitis obliterans, dangers, (council report) 693
thiosulfate in thromboangiitis obliterans, possible dangers, (Council report) 693
SOIL, Removal of: See Detergents
SOLDIERS: See Army; Veterans; World War II
Heart: See Asthenia, neurocirculatory
Medal: See World War II, Heroes
SOLIS-COHEN, SOLOMON, role in A. M. A. history, [Fishbein] ★384; (fights for clean advertising) ★390; ★464; ★470
SOMATIC Complaints: See Psychosomatic Medicine
SOMMER Lecture: See Lectures
SOOT fall averages 112 tons per square mile, N. Y. C., 562
SOPER, FRED L., director of Pan American Sanitary Bureau, 714
SOUND: See also Noise
cardiovascular and respiratory sounds, phonograph recordings, [Stokes] 429—ab
SOUTH AMERICA: See also Inter-American; Latin America; Pan America
Congress of Neurosurgery (2nd), 258
SOVIET Russia: See Russia
SPANISH American War, 1898, [Fishbein] ★471
Hispano-American Ophthalmology Society assembly, (24th) 567
Hispano-Portuguese Dermatology Congress (1st), 566
Hispano-Portuguese Urology Congress (5th), 567
moss, California, antibiotic from, [Marshak] 1245—ab
SPAS: See Health resorts
SPASM: See also Cramps; Tetany
ciliary, psychosomatic disorders, [Harrington] ★670
diagnosis, curare to differentiate from organic ch: nges, [Jones] 139—ab
proctalgias and perianal dyscrasias, [Granet] 127—ab
treatment, curare, bebeerine dimethylether methochloride, 882
treatment, curare in acute backache, [Schlesinger] 499—ab
treatment, neostigmine in rheumatoid arthritis, [Wramner] 1248—ab
SPEAKEERS: See also Speech
Bureau, (Reference Committee report), 36
Service, N. Y., 335
SPECIAL Formula Tablets 22, 568—BI
SPECIALISTS: See also under types of specialists
Certification: See American Board of, examination; Specialties
increase, Turkey, 1236
wanted for U. S. government positions, 48
SPECIALIZATION, A. M. A. and, [Fishbein] ★847
A. M. A. Committee on Medical Ethics dealing with, in 1866, [Fishbein] ★25
SPECIALTIES: See also under type of specialty as Ophthalmology
Examining Board: See also American Board examining board, cooperation in evaluating residencies, ★1081
examining board for certification of general practitioners, 43; 942—OS
SPECIFIC Pharmaceuticals, Inc., deaths from Analbis Suppositories, 852—E; [Weinstein] 962—C
SPECTACLES: See Glasses
SPEECH: See also Speakers; Voice
rehabilitation, program, Ill., 561
SPERMATOZOA, development, length of time, 811
preservation, for use in artificial insemination, 900
receptivity of cervical mucus to, [Barton] 140—ab
SPHINCTER MUSCLES, anal, preserve function in surgical cure of rectal cancer, [d'Allaines] 729—ab
SPIDER, flax, bite of, [Grille Cendan] 69—ab
SPINAL ANESTHESIA: See Anesthesia, spinal
SPINAL CORD: See also Cauda Equina
degeneration (possible subacute combined), 278; 1043
Inflammation: See also Encephalomyelitis; Meningoencephalitis; Poliomyelitis
inflammation after antirabic vaccine, [Bussell] 728—ab
injuries by chiropractor, [Pratt-Thomas & Berger] ★600
injuries, convalescent care and rehabilitation of patients (motion picture review), 1033

SPINAL CORD—Continued
injuries, urologic complications, [Bumpus & others] ★366; (apparatus used for tidal drainage or irrigation) [MacNeill] 1237—C
surgery, section for phantom limb, [Browder] 272—ab
SPINAL FLUID: See Cerebrospinal Fluid
SPINAL PUNCTURE, lumbar, reactions to, [Redlich] 649—ab
SPINE: See also Ribs
arthritis, Marie-Strümpell spondylitis, [Sokolow & Snell] ★985
arthritis, roentgen therapy of Marie-Strümpell spondylitis, 74
cervical rheumatic perispondylitis and cervical syndrome, [Belart] 141—ab; (correction) 377
dislocation, painful spongylolisthesis, Albee and Hibbs technics, [Puig Gurl] 650—ab
intervertebral disk, herniated, and sciatica, [Thiebaut] 430—ab
Intervertebral disk, herniated, National Neurologic Congress discuss, 1235
Intervertebral disk, ruptured bilateral and multiple, [Echlin] 205—ab
Intervertebral disk, ruptured cervical, electromyographic diagnosis, [Brazier] 721—ab
Intervertebral disk, ruptured, simulating angina pectoris, 1030
osteomyelitis (lumbar) in adult, [Freeman] 140—ab
SPIROCHETA Pallida: See Treponema pallidum
SPIROMETRY: See Respiration
SPLANCHNICETOMY: See Nerves
SPLANCHNOPTOSIS, generalized visceroptosis, 279
SPLEEN, calcifications in histoplasmin and tuberculin reactors, [High] 804—ab
Enlarged: See Splenomegaly
rupture, diagnosis, [Bierl] 503—ab
SPLENOMEGALY, treatment, epinephrine, 73
SPONDYLITIS: See Spine
SPONDYLOLISTHESIS: See Spine dislocation
SPONDYLOTHERAPY, Albert Abrams, 1911, [Fishbein] ★765
SPONGE, gelatin, as hemostatic dressing in anorectal surgery, [Rosser] 893—ab
SPOTTED FEVER: See Rocky Mountain Spotted Fever
SPRAY (pyogen) promoted to industry as "cold cure," (Joint Council report) 694
SPRUE, salt deficiency in, [Black] 352—ab
tropical, folic acid in, [Suarez] 724—ab; [Manson-Bahr] 894—ab
SQUASH, Beech-Nut Junior, 937
STAIN, picric acid, removal from hair, 734
STAMPS: See Postage Stamps
STANFORD University, (establishes eye bank) 875
STAPHYLOCOCCUS, diseases due to immunotherapy, [Pettersson] 968—ab
hemolytic, potency of stored penicillin against, [Pelczar] 720—ab
infection, action of brain tissue extract and penicillin on, [Nutini] 803—ab
infection, bacitracin for, [Meleney & Johnson] ★675
inhibited by inactivated penicillin, [Hunwicke] 727—ab
pneumonia (primary), penicillin for, [Davis] 1310—ab
toxin, antidotal property Penicillium notatum filtrates, 33—E
STARVATION, electrocardiogram in, [Forster] 736—ab
STATE, Board: See State Board
Board of Health: See Health
government and state medical society, [Barker] 549—ab
Hospitals: See Hospitals
Legislation: See Laws and Legislation federal and state
Medicine: See Medicine, state
Societies: See Societies, Medical
University of Iowa hospital administration program, 1163
STATE BOARD: See also Licensure
composite, and basic science, [various authors] 630—ab
STATISTICS: See Vital Statistics
STATUS Thymicolymphaticus: See Thymus
STATUTE of Limitations: See Medicolegal Abstracts at end of letter M
STEAM inhalations, value for colds, 1174
STEATOMA, infected sebaceous cyst, bacitracin for, [Meleney & Johnson] ★677
STEINBERG, A. J., bridge champion, 788—OS
STERILITY: See also Fertility; Impotence; Reproduction
American Society for Study of, 1st conference, 191
etiology, endocrine, in women, [Rubin] 726—ab
etiology, latent genital tuberculosis, in women, [Halbrecht] 69—ab
Inducing: See Sterilization, Sexual
male, of nonendocrine origin, endocrine therapy valueless, [Weisman] 198—C
receptivity of cervical mucus to spermatozoa, [Barton] 140—ab
Treatment: See Impregnation, artificial
STERILIZATION, BACTERIAL: See also Bactericides; Milk, pasteurization
of Air: See Air disinfection
of metal instruments, isopropyl alcohol for, 734
STERILIZATION, SEXUAL, vasectomy and tubal ligation as contraceptive, 1254
STERNBERG biography, [Fishbein] ★848
STEVENSON, SARAH HACKETT, first woman member of A. M. A., [Fishbein] ★175
STIBAMINE glucoside treatment of tuberculosis, [Rose] 269—ab
STIBOPHEN: See Fuadin
STIES: See Sty
STILBAMIDINE treatment of multiple myeloma, [Snapper] 64—ab; ★156
STILBESTROL: See Diethylstilbestrol
STILL, GEORGE A., osteopathic challenge in treating pneumonia, [Fishbein] ★929
STING: See Bees
STOCK: See Animals
STOCKS: See Investments
STÖCKEL-Göbell's Operation: See Urine incontinence
STOLL, ARTHUR, honored, 709
STOLZ, HAROLD F., personal, 488
STOMACH: See also Gastrointestinal Tract
acidity, achlorhydria, 278
cancer, Besredka's theory of immunity, 111—E
cancer, conference on, by Gastric Cancer Committee, 187
cancer, incidence; diagnosis, [Maimon] 206—ab
cancer, resectability; mortality, [Maimon] 205—ab
cyst (intrathoracic), [Dickson] 138—ab
dried, use to avoid allergy to liver extract, [Sullivan & Broun] ★178
Hemorrhage: See also Hematemesis; Peptic Ulcer
hemorrhage, rutin and sulfonamides incompatible [Kushlan] 716—C
hemorrhage, rutin therapy, 247—E
lavage, value in acute poisoning, 545—E; (technic described) [Kantor] 1238—C
Surgery: See Peptic Ulcer, surgical treatment; Stomach cancer
Ulcer: See Peptic Ulcer
STOMATITIS, ulcerative, (reply) [Stern] 146
Vincent's: See Angina, Vincent's
STONES: See Calculi (cross reference)
STOOLS: See Feces
STORAGE: See Penicillin; Serum, plasma
STRAPPING: See Adhesive
STRAUSS, Hermann, work on low salt diet in congestive heart failure in 1902, [Gossels] 497—E
STREPTOCOCCUS, anaerobic, multiple pyogenic liver abscesses, penicillin cures, [Michel & Wirth] ★395
Carrier: See also Streptococcus, hemolytic
carrier, penicillin for, [Jennings] 1303—ab
fecalis urinary tract infection, streptomycin for, [Adcock & Plumb] ★579
hemolytic, advances in study of, 322—E
hemolytic, nasal carriers, [Lemon] 137—ab
Infection: See also Rheumatic Fever; Scarlet Fever
infection, bacitracin for, [Meleney & Johnson] ★675
infection of respiratory tract, [Rantz] 132—ab
infection of throat, [Commission on Acute Respiratory Disease] ★588
S. B. E., endocarditis caused by, [Loewe] 63—ab
sulfonamide sensitivity of after using sulfadiazine, [Hartman] 723—ab
STREPTOMYCIN, antidotal property, 960
N.N.R., (description) 320; (Abbott; Merck; Pfizer), 321
supply, allocation to Veterans Administration increased, 787—OS
supply, controls, President asks continuance, 482—OS
supply, federal certification and inspection, 484—OS; 871—OS
titration by quick method of Janus green, 960
toxicity, [Madigan] 1246—ab
toxicity, otic complications [Fowler & Seligman] ★87
toxicity, pathologic changes, [Mushett] 1242—ab
Treatment: See also Cholera; Intestines infections; Meningitis; Peritonitis; Pylethrombophlebitis; Tuberculosis; Tuberculosis of Lungs; Tularemia; Urinary Tract infections; Wounds
treatment, clinical tests by Medical Research Council, England, 1234
treatment in Army hospitals, [DeBakey] 1036—ab
tubercle bacillus growth retarded by [Corper] 207—ab
STRIAE, breast, diagnostic significance, 358
STRIKES: See Physicians
STRUMA: See Goiter
Ovarii: See Thyroid tumor
STUDENTS: See also Children, school; Education; Schools; Students, Medical; University
ASTRP: See Army, United States, Specialized Reserve Training Program
Nurses: See Nurses
tuberculous infection, Porto Alegre, 714
STUDENTS, MEDICAL: See also Interns and Internships; Schools, Medical
Association of, 337
Fellowships: See Fellowships
in Paris, 420
loan fund (Freeman), Woman's Auxiliary cookbook to aid, 877
loan fund (Jane Todd Crawford), 1230
loans, applications open, Miss. 335; 876
Meek fund aid for superior students, 492
Prizes for: See Prizes
Scholarships: See Scholarships
supply, 944—OS
Teaching: See Education, Medical
tuberculosis in, [Morris] 62—ab
STUMICAID, 883—BI
STY, treatment, bacitracin, [Meleney & Johnson] ★675
SUCCINYLSULFATHIAZOLE treatment of ulcerative colitis, [Collins] 1171—ab
SUCROSE: See Sugar
SUCTION sockets, artificial limbs with, 703
tracheobronchial drainage by, [Foregger] ★1200
SUDECK'S Atrophy: See Osteoporosis, posttraumatic
SUGAR: See also Dextrose
excessive use, cause diabetes? 734
in Blood: See Blood sugar
in Urine: See Glycosuria
nutritive value of fats with, [Ershoff] 1304—ab
of Milk: See Lactose
Research Foundation, prizes for scientific studies, 52
tolerance tests, [O'Brien & Higgins] 197—C
SUICIDES of physicians in 1946, 108—E
sensitivity to amigen, [Ratner] 497—C
SULFADIAZINE, N.N.R., (Miller) 179
rutin incompatible with, [Kushlan] 716—C
toxicity, fixed eruption, [Cole] 720—ab
Treatment: See also Amebiasis; Plague; Pneumonia
treatment plus penicillin of pneumonia, [Dowling] 1171—ab
treatment plus penicillin routine use in appendectomy, [Griffin & others] ★907
treatment, preventive, of plague, [Platzer] 206—ab
treatment, preventive, of posttraumatic pneumonia, [Phillips] ★161
treatment, sulfonamide sensitivity of streptococci after, [Hartman] 725—ab
SULFADITAL, sulfa-combination, [Frisk] 1246—ab
SULFANILAMIDE, intrauterine use, [Sadovsky] 890—ab
SULFASUXIDINE: See Succinylsulfathiazole
SULFATE, ferrous, harmful effect of prolonged use? 655
SULFATHIAZOLE, Succinyl: See Succinylsulfathiazole
toxicity, asthma, [Rosberg] 1248—ab
toxicity, sensitivity to, and *not* to penicillin, [Labran] 1301—C
treatment, ointment, of wound, [Berczeller] 804—ab
treatment, resistance in gonorrhea increasing, [Nørgaard] 1248—ab
SULFHYDRYL treatment of corneal and x-ray burns, [Cruthirds] 131—ab
SULFOBROMOPHTHALEIN sodium, liver function test [Mateer & others] ★913; (in intravenous liver extract therapy of cirrhosis) [Labby & others] ★1184
SULFONAMIDE COMPOUNDS, effects on fetus, 970
sensitivity, 435
sensitivity of streptococci after sulfadiazine treatment, [Hartman] 723—ab
Sulfadiazine: See Sulfadiazine
sulfadital, a sulfa-combination, [Frisk] 1246—ab
Sulfanilamide: See Sulfanilamide
Sulfathiazole: See Sulfathiazole
toxicity, colitis, [Gauss] 719—ab
Treatment: See also Urinary Tract infection; Wounds
treatment of scarlet fever vs. convalescent serum and penicillin, [Hoyne & Brown] ★661
treatment plus penicillin for peritonitis, [Griffin & others] ★907; [Brown] 1241—ab
treatment plus penicillin for pneumococcic meningitis, [Ross] 892—ab
treatment plus penicillin for trachoma, [Lavery] 67—ab
SULFONE: See Promin
SULFUR dioxide, removal of odor from books, [Munkelt] 344—C
SUL-RAY-Effervescent Mineral Baths, 422—BI
SUNLIGHT, Sensitivity to: See Light
SUPERIOR Pulmonary Sulcus Tumor: See Thorax tumor
SUPPLIES: See Medical Supplies
SUPPOSITORIES, Analbis, deaths from, 852—E; [Weinstein] 962—C
SUPPURATION: See also Abscess; Ear, external; Otitis media; Ulcers; Wounds
treatment, chlorophyll, [Bowers] 1240—ab

SUPRARENALS: See Adrenals
SUPREME COURT: See Medical Jurisprudence
SURFACE TENSION of urine, hexylresorcinol effect on, [Inness-Brown] 1301—C
SURGEONS: See also Medicine, profession of; Physicians; Surgery
American College of, (inspection of American Cancer Society clinics; A. M. A. Committee report) 132: 1092; 133: 38; (fellowship pledge clause on fee splitting and rebates) [Patek] 715—C; (formation in 1914) [Fishbein] *770
Heroic Action of: See World War II, Heroes
Industrial: See Industrial Health
International College of, (purchases headquarters) 1025
Nordic Association of, Sweden, 1030
Royal College of, (fellowship, overseas examinations for) 121; (report) 261; controversy on National Health Service) 419
Surgeon General: See Army, U. S.; Health, USPHS; Navy, U. S.
SURGERY: See also under specific diseases, organs and operations as Abdomen; Cesarean Section; Peptic Ulcer; Tonsillectomy
Academy of, France, elect foreign members, 1234
American Board of: See American Board
A.M.A. requested to publish periodical on, [Fishbein] *762; *765; *844; *848
American Surgical Association resolutions on nursing problems, 1156—E; [Nafziger & others] 1168—C
Amputation: See Amputation
Anesthesia: See Anesthesia
Annals of Western Medicine and Surgery, new journal, 1227
Argentinean Congress of (17th), 343
blood loss in operations, [Baronofsky] 1036—ab
Early Rising after Operation: See Convalescence
fibrinolysis with, [Macfarlane] 805—ab
Infections in: See Infection, surgical
International Society of, London, 639; 961
Neurosurgery: See Neurosurgery
Operation (Illegal): See Abortion, criminal
Orthopedic: See Orthopedics
Philippine Journal of Surgery, new journal, 1231
postoperative abdominal adhesions, [Green] 723—ab
postoperative biliary dyskinesia, [Colp] 890—ab
Postoperative Infection: See Infection, surgical
postoperative thrombophlebitis and phlebothrombosis, [Meigs] 1035—ab
postoperative vomiting, and sedatives, 810
progress, drawbacks; ether and humbug, [Graham] *98
refrigeration and preservation of tissue, [Crossman & Allen] *377; [Pernworth] 1308—ab
Surgical Association of Piedmont, 495
Suture: See Suture
SURGICAL Dressings: See Dressings
Gloves: See Rubber gloves
Gut: See Catgut
SURMAN Lectureship: See Lectures
SURPLUS Products: See Medical Supplies, surplus
SUTURE, cotton, [Derbyshire] 1313—ab
cotton, vs. chromic catgut, [Stevens] 891—ab
surgical, surplus, sale of, 114
tendon, in finger amputations, 358
SWALLOWING: See Plummer-Vinson syndrome
SWANSON, CLIFFORD A., Surgeon General lauds Navy hospital corpsmen, 699—OS
SWEAT, congenital familial anhidrosis and neurolabyrinthitis, [Helweg-Larsen] 354—ab; 895—ab
hemilateral sweating, what causes? 1254
hyperhidrosis of face, 507
hyperhidrosis (unilateral frontal), supraorbital nerve section for, [Tarlov & Herz] *476
SWEDISH help fight venereal disease in Poland, 1030
Medical Board requests control of venereal disease, 712
Red Cross: See Red Cross
SWINDLERS: See Impostors
SWINE Erysipelas: See Erysipeloid
SWITZER, MARY E., awarded Certificate of Merit, 48
physician veterans difficulty in finding hospital staff appointments, 45
SWITZERLAND, Belgian gift of radium to, 118
nutrition during the war, [Fleisch] 354—ab
SYMPATHECTOMY, dorsolumbar, gastric ulcer aggravated by, [Blegen & Kintner] *1207
for peripheral vascular sclerosis, [de Takats & Evoy] *441
lumbar, in endarteritis obliterans, [Van Ouwerkerk] 652—ab
SYNCOPE, 811
Carotid Sinus: See Carotid Sinus
diagnostic problem, [Brian] 351—ab
SYPHILIS: See also Chancre; Venereal Disease; and under specific organ or disease affected
breast feeding by syphilitic mother, 810
SYPHILIS—Continued
Cerebrospinal: See Neurosyphilis
congenital, penicillin for, [Platou] 886—ab
Diagnosis: See Syphilis, serodiagnosis
early, nephropathies in, [Thomas] 888—ab
Incidence, effect of circumcision, [Wilson] 1243—ab
incidence higher among teen age groups, Mich., 792
mortality from, decline, 709
Neurosyphilis: See Neurosyphilis
of uterus cervix, [Guerriero & others] *834
serodiagnosis, false positive tests after tropical diseases, 73
serodiagnosis, false positive reactions in spinal fluid, 578
serodiagnosis, false positive tests in malaria, [Rein & Kent] *1001
serodiagnosis, incidence of positive tests in private practice, 507
serodiagnosis, Kahn test in healthy men, [Wolman] 128—ab
serodiagnosis, laboratory speeds up blood testing, N. Y. C., 414
serodiagnosis, premarital blood test regulations amended, Calif., 189
serodiagnosis, time of positive test before onset of chancre, 1174
treatment, arsenical intensive, agranulocytosis after, [Fisher] 1305—ab
treatment of early congenital type with penicillin, [Platou & others] *10
treatment, penicillin, acquired resistance of Treponema pallidum, 1282—E
treatment, penicillin in 1400 soldiers, [Sternberg & Leifer] *1
treatment, penicillin, Denmark, 961
treatment, penicillin, of recently acquired syphilis, infectious relapse after, 212
treatment, penicillin, problems arising in, [Hill] 1244—ab
SYRINGOBULBIA, surgical treatment, [Cramer] 133—ab
SYRINGOPONTIA, treatment, surgical, [Cramer] 133—ab
SYRUP, cough, [Boyd] 716—C

SOCIETIES AND OTHER ORGANIZATIONS

Acad.—Academy
Am.—American
A.—Association
Coll.—College
Commn.—Commission
Comm.—Committee
Conf.—Conference
Cong.—Congress
Dist.—District
Div.—Division
Found.—Foundation
Hosp.—Hospital
Indust.—Industrial
Inst.—Institute
Internat.—International
M.—Medical
Med.—Medicine
Nat.—National
Pharm.—Pharmaceutical
Phys.—Physicians
Soc.—Society
Surg.—Surgery
Surgs.—Surgeons
S.—Surgical

Acad. of Med. (Niagara Falls, N. Y.), 49
of Medicine of Northern New Jersey, 189
Adams County (Ill.) M. Soc., 489
County (Ill.) Public Health Department, 1227
Advisory Council of Presidents and Secretaries of the M. Socs. of the Eighth Judicial Dist. (N. Y.), 414
Agricultural Workers Health and M. A., 706
Alabama A. of Obstetricians and Gynecologists, 791
M. A. of the State of, 954
Alameda County (Cal.) M. Soc., 1022
Alaska Native Service, 336
Territorial Department of Health of, 336
Albany, M. Soc. of the County of (N. Y.), 413
Alcoholics Anonymous, 334, 876
Alpha Epsilon Delta, 258
Kappa Kappa, 791, 1227
Am. Acad. of Allergy, 117
Acad of Dermatology and Syphilology, 191
Acad. of Orthopaedic Surg., 192
Acad. of Pediatrics, 794, 878, 1025
Anti-Arthritis A., 1230
A. for the Advancement of Science, 191, 416
A. for Practical Nurses Education, 794
A. for the Study of Goiter, 794
A. of Indust. Dentists, 1165
A. of Indust. Nurses, 1165
A. of M. Record Librarians, 639
A. of Obstetricians, Gynecologists and Abdominal Surgs., 192
A. of Psychiatric Clinics for Children, 878
Board of Obstetrics and Gynecology, 956
Board of Ophthalmology, 257
Board of Otolaryngology, 708
Board of Pathology, 1165, 1295
Board of Psychiatry and Neurology, 191
Board of Surg., 337
Book Center for War Devastated Libraries, 878
Bureau for M. Aid to China, 709
Cancer Soc., 49, 115, 255, 335, 412, 415, 492, 562, 639, 706, 955, 1024, 1025, 1165, 1292
Chemical Soc., 414, 794, 878
Coll. of Allergists, 878, 1294, 1295
Coll. of Chest Phys., 563, 708, 1025
Coll. of Phys., 492, 957
Coll. of Radiology, 337
Coll. of Surgs., 192, 337, 638, 708
Societies and Other Organizations—Continued
Am.—*Continued*
Conf. of Governmental Indust. Hygienists, 1165
Diabetes A., 1293
Found. for High Blood Pressure, 117
Found. for Tropical Med., 192
Heart A., 49, 563, 639
Hosp. A., 51
Industrial Hygiene A., 1165
Inst. of Nutrition, 51, 794
Laryngological A., 708
Laryngological, Rhinological and Otological Soc., 708
M. A., 191, 563, 707, 709, 877, 1228, 1295
Neurological Soc., 878
Nurses A., 191
Occupational Therapy A., 257, 709
Orthopsychiatric A., 415
Orthoptic Council, 794
Otological Soc., Inc., 708
Pharmaceutical A., 52, 708
Pharmaceutical Manufacturers' A., 52, 337
Psychiatric A., 117, 561, 878
Phys. Literary Guild, 257, 1165
Public Health A., 51, 639, 877
Red Cross, 51, 412, 415, 492, 638, 639, 707
Red Cross Nursing Service, 191
Soc. for Research in Psychosomatic Problems, 1165
Soc. for the Study of Arteriosclerosis, 1025
Soc. for the Study of Sterility, 191
Soc. of Electroencephalography, 117
Soc. of Parasitologists, 117
Soc. of Tropical Med., 117
S. A., 337
Urological A., 638
Women's A., 256
Arkansas M. Soc., 1022
A. for Research in Nervous and Mental Disease, 117
for the Advancement of Research in Multiple Sclerosis, 878
for the Study of Internal Secretions, 258
of Am. M. Colls., 51, 492
of Am. Railroads, 1295
of Indust. Phys. and Surgs., 1165
of Interns and M. Students, 337
of Philadelphia Scientists, 563
Billings, Frank, Found., 189, 561
Boston University School of Med., Alumni A. of the, 1163
Brazilian Soc. of Cardiology, 258
British M. A., 706
Brooklyn, Acad. of Med. of, 335
Cancer Comm., 256
Cancer Inst., 256
Brush Found., 706
California Board of M. Examiners, 1291
Cancer Comm., 49
League of Women Voters, 1291
M. A., 412, 1227
Soc. of Internal Med., 636
State Department of Education, 791
State Department of Health, 791
State Department of Mental Hygiene, 334
State Personnel Board, 954
Canadian Physiological Soc., 794
Catholic Charities of the Diocese of Brooklyn, 707
Central A. of Obstetrics and Gynecologists, 191, 563
M. Soc. (Pa.), 954
New York Eye, Ear, Nose and Throat Soc., 1295
Pennsylvania Allergy A., 707
Pennsylvania Indust. Health Conf., 956
Soc. for Clinical Research, 336
West Virginia M. Soc., 51
Chamber of Commerce of the U. S., 51
Charleston County (S. C.) Tuberculosis A., 793
Chicago and Cook County, Tuberculosis Inst. of, 255, 488, 1023, 1163
Bar A., 334, 636
Dermatological Soc., 1227
Health Department, 255
Heart A., 1023
Inst. for Psychoanalysis, 1023
Inst. of Med. of, 115, 189, 191, 334, 636, 637, 1292
M. Soc., 115, 334, 412, 489, 637, 954, 1163
Ophthalmological Soc., 115
Public Health Inst. of, 334, 1292
Soc. of Internal Med., 49
Tuberculosis Soc., 255, 1023
Children's Bureau, 561
Christian Community Club (N. Y. C.), 876
Cinchona Products Inst., 257
Cincinnati, Acad. of Med. of, 50, 491, 637
Civilian Production Administration, 1024
Clark County (Wash.) Dist. Health Department, 793
Cleveland, City of, Division of Health, 1024
Diabetes Soc., 336
Found., 336
Health Museum, 1024
Radiological Soc., 415
Clinical Soc. of the Beth El Hosp., 256
Colorado Civil Service Comm., 412
State Board of Health, 412
State M. Soc., 489
Columbia County (N. Y.) M. Soc., 116
Community Service Soc. (N. Y. C.), 876

V
19

Societies and Other Organizations—Continued
Connecticut Board of M. Examiners, 334
Cancer Soc., 1227
Department of Aviation, 255
M. Examining Board, 255
Rehabilitation A., 1227
Selective Service System, 255
State Department of Health, 116
State M. Soc., 255, 412, 636, 706, 1022, 1291
Cook County (Ill.) Commn., 334
County Department of Public Health, 1163
Coordinating Council of the Five County M. Socs. of Greater New York, 955
Cox, George S., M. Research Inst., 50
Dallas County (Tex.) M. Soc., 1229
Southern Clinical Soc., 491
Dauphin and Perry Counties (Pa.), Tuberculosis and Health Soc. of, 956
County (Pa.) M. Soc., 956
Davidson County (Tenn.) M. Soc., 190
Delta Gamma Fraternity of Coll. Women, 794
Detroit Dermatological Soc., 413
Otolaryngological Soc., 413
Pediatric Soc., 413
Physiological Soc., 490
Diplomates A. of Berks County (Pa.) Phys., 877
Eastern A. of Electroencephalographers, 52, 117, 337
Colorado M. Soc., 115
Kentucky M. A., 954
Empire Rheumatism Council, 52
Erie County (Pa.) Health and Tuberculosis A., 116
Evanston (Ill.) Board of Health, 561
Excerpta Medica, Inc., 416
Eye Bank for Sight Restoration, Inc., 492
Fairfield County (Conn.) M. A., 954
Federal Bureau of Investigation, 416
Food and Drug Administration, 708
Federation of State M. Boards, 956
Florida Basic Science Board, 1022
Board of M. Examiners of, 1022
M. A., 1022
Neurology and Psychiatry Soc., 1022
Public Health A., 489
State Board of Health, 561
State Tuberculosis Board, 791
Food and Agriculture Organization, 956, 1231
French Soc. of School Hygiene, 52, 118
Fulton County (Ga.) M. A., 794, 1227
General Practice of Med. Soc., 1022
Genessee County (Mich.) M. Soc., 413, 562
Georgia, M. A. of, 1227
Warm Springs Found., 1163
Gorgas Memorial Inst., 192
Gould, Robert, Research Found. of Erlanger (Ky.), 708
Greenville County (S. C.) M. Soc., 190
Hadassah Women's Zionist Organization of America, 416
Hawaii Territorial M. A., 1294
Heberden Soc., 52
Heed Ophthalmology Found., 1230
Hektoen Inst. for M. Research, 954
Hematology Research Found., 412
Hennepin County (Minn.) M. Soc., 49, 1163
Hillsborough County (Fla.) Health Department, 489
Hodgkin's Disease Research Found., 708
Houghton-Baraga-Keweenew County (Mich.) M. Soc., 490
House Officers' A. of Boston City Hosp., 256, 413, 706
Hudson County (N. J.) M. Soc., 876
Humbolt Rotary Club, 792
Illinois Civil Service Commn., 255
Department of Public Health, 115, 255, 334, 791, 954, 1163
Public Health A., 1163
Soc. for Mental Hygiene, 561, 791
State Dental Department, 561
State M. Soc., 706, 1023, 1292
Statewide Health Comm., 334
University of, Alumni A., 1291
Indian Radiological A., 416
Indiana State Board of Health, 875
State M. A., 412, 489, 1023
Indianapolis (Ind.) M. Soc., 115
Obstetrical and Gynecological Soc., 1023
Ingham County (Mich.) M. Soc., 256
Inst. of Experimental Biology, 189
of Rehabilitation and Med., 50, 256
of Pacific Relations, 1291
Instituto Nacional de Nutricion, 118
Pasteur (Lisbon), 258
Internat. Acad. of Legal and Social Med., 564
and Spanish Speaking A. of Phys., 639
and Spanish Speaking A. of Phys., Dentists and Pharmacists, 1230
A. of Allergists, 564
Children's Emergency Fund, 956, 1231
Coll. of Surgs., 1025
Cong. of Military Med., 1231
Cong. of Obstetrics and Gynecology, 416
Labor Organization, 956, 1231
League Against Epilepsy, 117
Red Cross, 1231
Refugee Organization, 956, 1231
Soc. of Surg., 639
Interstate Postgraduate M. A., 1025
Iowa Comm. for the Study of Venereal Diseases, 954
State Department of Health, 954
Iowa—*Continued*
State Fly Control Conf., 954
State M. Soc., 876
Irish Ophthalmological Soc., 1228
Isthmian Canal Zone, M. A. of the, 117
Italo-Am. Center for M. Science, 1231
Jefferson County (N. Y.) M. Soc., 190
Jewish Board of Guardians, 637
Consumptives Relief Soc., 115
Joint Comm. for Research in Problems of Cerebral Palsy, 1164
Kalamazoo (Mich.) Acad. of Med., 792
Kansas Local Health Officers' Conf., 489
M. Soc., 792, 1292
State Board of Health, 561, 792, 1292
Kappa Sigma Fraternity, 50
Kellogg Found., 1163
Kentucky State M. A., 189
Kings, M. Soc. of the County of (N. Y.), 335
Lake County (Ind.) M. Soc., 115
County (Ind.) Tuberculosis A., 115
Lehigh County (Pa.) M. Soc., 956
Levy, Joseph and Helen Yeamans, Found., 490
Liberian Inst., 192
Litchfield County (Conn.) M. A., 255
Los Angeles County M. A., 561, 1227
Louisiana-Mississippi Ophthalmological and Otolaryngological Soc., 1293
Mahoning (Ohio) M. Soc., 1229
Maine Board of Registration of Med., 1293
Maryland, M. and Chirurgical Faculty of the State of, 1025, 1163
Massachusetts Department of Public Health, 1228
M. Soc., 1023, 1293
Medico-Legal Soc., 256
Phys. Art. A., 1023
State Department of Public Health, 489
Mayo Found. for Med., Education and Research, 337
Maywood (Ill.) Community Planning Council, 1163
Maywood-Melrose Park (Ill.) Health Center Comm., 1163
M. and S. Relief Comm. of America, 1025
Library A., 1165
Menninger Found., 792
Mexican Soc. of Tropical Med., 118
Michigan A. of Industrial Phys. and Surgs., 706
Department of Health, 335
Postgraduate Clinical Conf., 413
State M. Soc., 335, 490
Middle Tennessee M. A., 190
Middlesex County M. Soc., 1023
Milwaukee County (Wis.), M. Soc. of, 956
Minnesota Department of Health, 562
Public Health A., 490
State Board of M. Examiners, 490, 562
Mississippi State Board of Health, 956
State M. Education Board, 335
Valley M. Soc., 191
Missouri State M. A., 876
Monroe, M. Soc. of the County of (N. Y.), 414
Multnomah County (Ohio) M. Soc., 1229
Nashville Acad. of Med., 190
Nat. Acad. of Sciences, 52
Advisory Council, 876
Advisory Health Council, 791
Advisory Mental Health Council, 792, 1023
A. for the Prevention of Tuberculosis (G. Br.), 709
A. of Boards of Pharmacy, 708
Better Business Bureau, 191
Brucellosis Comm., 118
Cancer Found., 955
Cancer Inst., 793, 1024
Cancer Inst. (Canada), 1231
Comm. for Mental Hygiene, 117, 415, 876, 878
Conf. of Social Work, 639
Conf. on Health in Colls., 563
Conf. on M. Service, 337
Council of Jewish Women, 637
Council of Scientific Investigations of Spain, 637
Council on Rehabilitation, 708
Found. for Infantile Paralysis, 117, 256, 257, 415, 490, 492, 639, 709, 792, 1024
Health Council, 639
Health Service (G. Br.), 709
Inst. of Allergic Diseases (Argentina), 564
Inst. of Health, 791, 1024
Malaria Soc., 191
Mental Health Found., 1230
Organization of Public Health Nursing, 191, 639
Research Council, 118, 256, 492
Safety Council, 564, 639, 1294
Soc. for Crippled Children and Adults, 878
Soc. for the Prevention of Blindness, 258, 562, 794
Soc. of M. Research, 51
Tuberculosis, A., 190, 564, 639, 956
Nebraska State M. A., 256, 490, 1228
New England Diabetes A., 1025
Soc. of Physical Med., 49, 639
State M. Socs., Council of, 1230
S. Soc., 337
New Jersey Diabetes A., 1293
Induction Examining Board, 335
M. Soc. of, 1023
Mosquito Extermination A., 1293
Orthopedic Soc., 190
New Jersey—*Continued*
Rehabilitation Commn., 1164
Soc. of Surgs. of, 49
New Mexico M. Soc., 1024
New York Acad. of Med., 116, 190, 414, 415, 793, 876, 1024
City Cancer Comm., 335, 491
City Health Department, 256, 637, 877, 1164
Diabetes A., 49, 117, 876
Found., 256
Health Council of Greater, 707
Inst. of Clinical Oral Pathology, 190
Lions Club, 50, 637
M. Soc. of the State of, 50, 256, 335, 413, 637, 793
Psychiatric Inst., 414
Rheumatism A., 1228
Soc. of Neurosurgeons, 116
State Department of Civil Service, 562
State Health Department, 50, 116, 192, 255, 256, 335
State Joint Legislative Comm. on Cerebral Palsy, 335
State Nurses A., 490, 562
State Public Health Council, 955
Tuberculosis and Health A., 707, 955
Tuberculosis Sanatorium Conf. of Metropolitan, 1024
Northern M. A., 257
Tri-State M. A., 708
Northwestern University Alumni A., 637
Office of Indian Affairs, 336
Ogden S. Soc., 1024
Ohio Department of Health, 491, 563
State M. A., 1293
Oklahoma Hosp. A., 414
M. Research Found., 414
Ortho Research Found., 708
Oxford, Inst. of Social Med. of, 190
Pacific Coast S. A., 337
Pan Am. A. of Philadelphia, 257
Cong. of Ophthalmology, 492
Cong. on Tuberculosis, 563
Rheumatism League, 52
Sanitary Bureau, 639
Sanitary Conf., 639, 1230
Sanitary Education Conf., 1230
Passaic County (N. J.) M. Soc., 876
Pasteur, Louis, Inst., 192
Pediatric Found., 335
Pennsylvania Acad. of Ophthalmology and Otolaryngology, 1229
Department of Health, 50, 336, 956
M. Service A. of, 257
M. Soc. of the State of, 257, 956
Psychiatric Soc., 50
Tuberculosis Soc., 877, 956
Perry County (Ill.) M. Soc., 115
Phi Beta Pi Fraternity, 877, 956
Chi M. Fraternity, 956
Lambda Kappa, 708
Philadelphia County (Pa.) M. Soc., 707, 1024, 1164, 877
Roentgen Ray Soc., 50
Tuberculosis and Health A., 877
Phillipine Coll. of Surgs., 1231
Phipps, Henry, Inst. for the Study, Treatment and Prevention of Tuberculosis, 877
Planned Parenthood Federation of America, 337
Plotz, Ella Sachs, Found., 416
Presbyterian Hosp. A. of Orange County (Cal.), 636
Provisional Internat. Civil Aviation Organization, 956, 1231
Psychiatric Found., 878
Public Health Cancer A. of America, 192
Puerto Rico, A. of Social Workers of, 1230
Department of Health of, 51, 336, 638, 1230
M. A. of, 51, 638
Pharmaceutical A., 708
Planning Board of, 336
Public Health A., 708
Queens County (N. Y.) Cancer Comm., 562
Quincy (Ill.) Public Health District, 1227
Ramsey County (Minn.) M. Soc., 1163
Reading (Pa.) Eye, Ear, Nose and Throat Soc., 414, 877
Red Cross, see Am. or Internat. Red Cross
Internat. Comm. of the, 878
Rensselaer, M. Soc. of the County of (N. Y.), 256
Research Council on Problems of Alcohol, 334, 335
Research Study Club, 189
Rhode Island M. Soc., 1294
Richland County (S. C.) Tuberculosis A., 1229
Richmond County (N. Y.) M. Soc., 50
Riggs, Austen, Found., 792
Rochester (N. Y.) Acad. of Med., 414
Board of Education of, 414
and Monroe County (N. Y.), Tuberculosis and Health A. of, 414
Rockefeller Found., 117, 337, 489, 564, 659, 1230, 1294
Inst. for M. Research, 878
Rocky Mountain M. Conf., 1024
Rosenstock Memorial Found. Inc., 955
Royal Coll. of Phys. (Edinburgh, Scotland), 258
Soc. of Arts, 878
St. Louis County (Mo.) M. Soc., 707, 1163
San Diego County (Cal.) M. Soc., 334
Santa Clara County (Cal.) Health Department, 708

Societies and Other Organizations—Continued
Saranac Lake (N. Y.) M. Soc., 1228
Schiff, Mortimer and Adele, Found., 1024
Seaboard M. Soc., 51
Sealy and Smith Found. of Galveston (Tex.), 1164
Seattle (Wash.) Neurological Soc., 1025
Seeing Eye, 191
Sloan-Kettering Inst. for Cancer Research, 335, 414
Sociedad Argentina de Pediatria, 957
Nacional de Cirugia of Cuba, 957
Ycateca de Obstetricia y Ginecologia, 118
Soc. for Clinical Investigation, 336
for Vascular Surg., 257
of Am. M. Colls., 708
of Bacteriologists, 414
of General Phys., 491
of Illinois Bacteriologists, 189
of M. Inspectors, 52, 118
of Physical Med., 1295
of University Surgs., 639
South Am. Cong. of Neurosurgery, 258
South Carolina M. A., 1229
Tuberculosis A., 190
Southeastern S. Cong., 708
Southern California Soc. for Mental Hygiene, 334
M. A., 117, 1230
Soc. for Clinical Research, 878
S. A., 191, 337
Southwest Allergy Forum, 563
Southwestern M. Found., 415, 793
Spokane County (Wash.) M. Soc., 491
Squibb Inst. for M. Research, 192
State Charities Aid A., 794
Sugar Research Found., 52
Sullivan County (Ind.) M. Soc., 1228
Summit M. Soc., 257
Sunset Camp Service League, 636
Telfair-Wheeler Dist. (Pa.) Health Department, 954
Tennessee State M. A., 1229
Texas Hosp. Service, 491
M. Center, 297
Soc. of Pathologists, 638
State Board of Health, 638
State M. A. of, 1164, 1229
Tompkins County (N. Y.) M. Soc., 413
Triological Soc., 708
Tri-State M. A., 1294
Trudeau Soc. of Los Angeles, 561
Tumour Clinic A. of the State of New York, 256
UNESCO, 956, 1231
United Nations, 957, 1231
Educational, Scientific and Cultural Organization, see UNESCO
Social Affairs Department, 956
Relief and Rehabilitation Administration, see UNRRA
U. S. A. of State and Territorial Health Officers, 1293
U. S. Bureau of Animal Industry, 875
Federal Security Agency, 1230
Public Health Service, 49, 116, 189, 192, 253, 334, 413, 416, 489, 490, 491, 561, 708, 875, 954, 1024, 1025, 1164, 1229, 1292, 1294
Weather Bureau, 334
UNRRA, 258, 638, 956, 957, 1231
Vermont State M. Soc., 638
Veterans Administration, 51, 190, 414, 415, 562, 956, 1292
Virginia, State Department of Health of, 116
Wainwright Tumor Clinic A., 956
War Assets Administration, 255
Washington State M. A., 707
State Restaurant A., 793
Wayne County (Mich.) M. Soc., 792
Western New York Hosp. Council, 490
Soc. for Clinical Research, 336
State Psychiatric Inst. and Clinic, 337, 1024
S. A., 337
West Virginia Cancer Soc., Inc., 415
State M. A., 257, 415, 491, 1294
Winnebago County (Ill.) M. Soc., 636
Wisconsin Department of Veteran Affairs, 956
State M. Soc., 877, 956
S. Soc., 51
Women's M. A., 51
World Health Organization, 117, 258, 956, 1231
M. Organization, 878

T

TABES DORSALIS, probable gastrointestinal lesion, 278
TABLEWARE: See Cooking and Eating Utensils
TACHYCARDIA, paroxysmal, acetylcholine for, [Segers] 729—ab
paroxysmal, transitory, [Jervell] 504—ab
TAFT, ROBERT, asks billion dollar budget for social welfare, 947—OS
planning for health by, 180—E
TAFT-Fulbright Bill (S. 140) U. S. Department of Health, Education and Security, 180—E; 185—OS; 398—E; 482—OS; (Joint Committee report) 943—OS; (A. M. A. position on) 1015; (conclusion of hearings on) 1159—OS
Smith-Ball-Donnell National Health Bill, 36; 479—E; 556—OS; 855—E; 868—OS; 943—OS
TALC granuloma, [Lichtman] 206—ab
infected, tetanus from, fatal to 3 infants, Australia, 1031
TALKING: See Speakers; Speech; Voice
TANTALUM in tendon reconstruction, [Pearlman] 206—ab
TAPE: See Adhesive
TARTAR, Cream of: See Potassium bitartrate
TASTE and food selection in hypoglycemia, [Mayer-Gross] 573—ab
TATTOOING, cornea, use of platinum or gold chloride plus epinephrine, [Knapp] 358
TAVERNS, sanitation, lack, Chicago, 255
TAX: See also Medicolegal Abstracts at end of letter M
income, and state associations, [various authors] 551—ab; [McDavitt & others] 627—ab
income, physician's, 401—E; 402—OS
TEACHERS: See also Professors
shortage increasing, 696—E
TEACHING: See Education, Medical
TECHNOLOGISTS: See also Occupational Therapy; Physical Therapy
electroencephalography, needed by Veterans Administration, 113
medical, fatal poliomyelitis virus infection, [Wenner] 1303—ab
medical, giving anesthetics and doing x-ray work, 1920, [Fishbein] *923
medical, granted degree, Penn., 877
medical, in hospitals, statistics, *1077; 1158—E
medical, schools for approved by A. M. A., *1150
Russian, training 1,980,000 in 5 years, 788—OS
TEETH: See also Dentistry; Jaws
artificial, recurrent buccal vesicles from, 656
care (free), Eastman Institute provides for children, Stockholm, 712
caries and food habits, [Neumann] 1037—ab
caries, experiment in, Norway, 263
caries-fluorine hypothesis, [Downs] 499—ab
caries, fluorine in water, safe level, 734
caries, fluorine research project, Evanston, 561
caries, topical sodium fluoride in, [Knutson] 573—ab
enamel, erosion, oxalic acid protects against, 1010—E
lemon juice dissolves substance of, 1218—E
surgery, intravenous barbiturates for, 812
TELANGIECTASIA, hereditary hemorrhagic (Rendu-Osler-Weber Disease), rutin for, 247—E
treatment, rutin and sulfonamides incompatible, [Nushlan] 716—C
TELEVISION programs by A. M. A., 326—OS
TEMPERATURE: See Cold; Heat; Tropics; Weather
TEMPERATURE, BODY: See also Fever
as guide to determine time of death, 195
TEMPLETON'S Raz-Mah Capsules, 568—BI
TENDONS reconstruction, tantalum, [Pearlman] 206—ab
sutures in finger amputations, 358
transplantation in hand, [May] 206—ab
TENSION: See Surface Tension
Nervous: See Mental Tension
TERATOMA: See Epidermoid
TERMINOLOGY: See also "Words and Phrases" under Medicolegal Abstracts at end of letter M
A. M. A. and nomenclature, [Fishbein] *103; *468
clinical pathology, 213
doctors urged to use "plain English," 1015—OS
eponyms, [Wolf] 344—C
health center defined (Reference Committee report), 36
"normal," what is it? 1011—E
sectarian practice and physician defined by A. M. A., [Fishbein] *933
state medicine defined by A. M. A., [Fishbein] *923; *928
TESTIMONY, Expert: See Evidence
TESTIS, atrophic, removal, 656
Hormone: See Androgens
inflammation, mumps orchitis, [Nixon] 1243—ab
TESTOSTERONE: See Androgens
TEST-Tube Baby: See Impregnation, artificial
TETANUS a preventable disease, [Glenn] 720—ab
from infected talc, 3 babies die, Australia, 1031
serum (high titer), production, [Buer] 1317—ab
treatment, bebeerine dimethylether methochloride, curare substitute, 882
treatment, penicillin, [Lewis] 1171—ab
TETANY after mercurial diuresis, [Marshall] *1007
TETRACHLORETHYLENE treatment of fasciocobiasis infection, 900
TETRAETHYLAMMONIUM Ion: See Ethylammonium Ion
TETRATHIONATE in thromboangiitis obliterans, possible dangers, (Council report) 693
TEXAS, Q fever in, [Topping & others] *813; [Irons & Hooper] *815; [Irons & others] *819; [Cox & others] *820
University of: See University
THEOCIN: See Theophylline
THEOPHYLLINE (theocin) N.N.R., (Miller), 321
THEOPHYLLINE ETHYLENEDIAMINE (aminophylline), N.N.R., (Dubin; Premo) 179; (Barlow-Maney; Premo) 937
treatment of acute coronary occlusion, 357
THERAPEUTICS: See also Blood Transfusion; Diathermy; Drugs; Fever, therapeutic; Occupational Therapy; Physical Therapy; Roentgen Therapy; etc. under names of specific substances
A. M. A. Therapeutic Trials Committee, cost of clinical research, *30
Bed Rest in Treatment vs. Early Rising: See Convalescence
Self-Medication: See Self-Medication
THERMOTHERAPY: See Diathermy; Heat, Therapeutic use
THIAMINE HYDROCHLORIDE: See also Vitamin B1
assay in Haskell's Pantabee, [Haskell] 645—C
deficiency and diet high in carbohydrate, [Ring] 1304—ab
labor accelerated with, Russia, 122
N.N.R., (Harrower; Yale) 619; (Miller) 1009
treatment of myasthenia gravis, 1252
THIOMALATE, lithium antimony, treatment, [Brown] 268—ab; [Kose] 269—ab
THIOSULFATE: See Sodium thiosulfate
THIOURACIL, methyl, in thyrotoxicosis, 544—E; [Frisk] 574—ab; [Poate] 1172—ab
N.N.R., (description) 619; (Abbott, Parke Davis; Rorer; Squibb; Winthrop) 619
propyl, in hyperthyroidism, [Astwood] 506—ab
propyl, in thyrotoxicosis, [Reveno] *1190
toxicity, complications, [Belerwaltes] 570—ab
treatment of angina pectoris, disadvantages, [DiPalma] 127—ab
treatment of congestive heart failure with 2-thiouracil, [Sharpey-Schafer] 805—ab
treatment of hyperthyroidism, [Bartels] 893—ab; [Hadorn] 967—ab
treatment of hyperthyroidism in pregnancy, 73
treatment of hyperthyroidism with derivatives, 544—E
treatment of ulcerative colitis, [Martin] 1037—ab
THORACOPLASTY, revision, [Hochberg] 804—ab
THORAX: See also Chylothorax; Pneumothorax; Ribs
Chest X-Ray: See Tuberculosis, case finding
injury (battle), traumatic chylothorax resulting from, [Berry] *319
injury, pneumonia after, [Phillips] *161
intrathoracic meningocele, [Cabello Campos] 730—ab
stereoroentgenograms in esophageal leiomyoma, [Schafer & Kittle] *1202
surgery of chest, rehabilitation after, 1029
Transthoracic Vagotomy: See Nerves
tumor, superior sulcus pulmonary (Pancoast syndrome), [Wichtl] 354—ab; [Walker] 890—ab
THORNTON, EDWARD, death, 492
THRESHER'S disease, [Hoffmann] 652—ab
lung, [Tornell] 504—ab
THROAT: See also Larynx; Nasopharynx; Neck; Otolaryngology; Tonsils
infections (acute), penicillin for, [Faucett] 572—ab
Sore: See also Tonsils, infected
sore, neurologic disease after, [Bronson] 500—ab
sore, of unknown cause, [Commission on Acute Respiratory Diseases] *588
Sore (Quinsy): See Abscess, peritonsillar
streptococci (hemolytic), 322—E
THROMBASTHENIA, hereditary hemorrhagic, pseudohemophilia, [Perkins] 349—ab
THROMBECTOMY for venous thrombosis and pulmonary embolism, [Allen & others] *1268
THROMBIN: See also Blood coagulation; Blood prothrombin
in suprapubic prostatectomy [Quinby] 203—ab
THROMBOANGIITIS OBLITERANS, coffee not contraindicated in, 73
treatment, inject 1 (—) histidine monohydrochloride-sodium ascorbate, [Wirtschafter & Widmann] *604
treatment, tetrathionate, possible dangers (Council report) 693
THROMBOCYTOPENIA: See Purpura, thrombopenic
THROMBOPHLEBITIS: See also Phlebothrombosis; Pylethrombophlebitis
in gynecologic patients, [Meigs] 1035—ab
trauma and, 280
treatment, [Aycock & Hendrick] *1262
treatment, [Allen & others] *1268
THROMBOSIS: See also Embolism; Phlebothrombosis
carotid (internal) primary, [Milett] 430—ab
cerebellar, chiropractor induce, [Pratt-Thomas & Berger] *600
cerebral (recurrent), as nosologic entity, 940—E
coronary, and anticoagulants, 970
coronary, changes in blood coagulation after, [Ogura] 137—ab
coronary, effects of cholagogues on, 146
venous, problem, [Aycock & Hendrick] *1258

THROMBOSIS—Continued
venous, heparin in Pitkin menstruum for, [Loewe & Hirsch] ★1263
venous, treatment, [Allen & others] ★1268
THYMECTOMY: See Thymus excision
THYMOL turbidity test of liver function, [Mateer & others] ★911; (in liver cirrhosis) [Labby & others] ★1185
THYMUS excision in myasthenia gravis, 1252
hypertrophy, 644
status thymicolymphaticus, 644
THYROID: See also Goiter; Goiter, Toxic
cancer, [Cattell] 273—ab
extract, administration, 578
extract, diabetes after prolonged use, 195
extract, growth promoting agents, 898
extract, treatment of obesity, [Freed] ★372
Hyperthyroidism: See Hyperthyroidism
Hypothroidism: See Hypothyroidism
lability of bone, mobilization of minerals and salts from skeleton, 110—E
tumor, struma ovarii, [Smith] 722—ab
THYROTOXICOSIS: See Goiter, Toxic
TIC: See Spasm
TICKS, Fever from: See Rocky Mountain Spotted Fever
TIDAL Drainage; Irrigation: See Bladder
TIMM, O. K., personal, 1020
TINEA capitis (ringworm of scalp), [Steves & Lynch] ★306
TINNITUS aurium, with mild perceptive deafness, 436
TIRE: See Rubber Tire
TISSUES: See also Skin; under names of specific organs
Cells: See Cells
Deproteinated Extract: See Pancreas
effect of brown fat extracts on metabolism, 436
extracts (animal) effects on wound healing, [Hoffman] 720—ab
preservation, and surgical refrigeration, [Crossman & Allen] ★377; [Pernworth] 1308—ab
reactions induced by fibrinogen plastics, [Bailey] 721—ab
reactions to cold, [Friedman] 200—ab
therapy of retinitis pigmentosa, [Lipkina] 652—ab
TNT: See *tri*Nitrotoluene
TOBACCO habit and cigarets, minor immoralities of 1899, [Fishbein] ★474
TOES, hallux valgus, Fairyfoot for, 568—BI
recurrent erysipelas-like eruption between, 655
TOLUENE: See *tri*Nitrotoluene
TONGUE changes in British troops, [Smith] 68—ab
inflammation, pellagrous glossitis, folic acid for, [Spies] 425—ab
TONSILLECTOMY, number of deaths under general anesthesia for, 507
TONSILLITIS: See Tonsils, infected
TONSILS, Abscess: See Abscess, peritonsillar
Excision: See Tonsillectomy
Infected: See also Angina, Vincent's
Infected, deaths after Analbis Suppositories, 852—E; [Weinstein] 962—C
infected, exudative tonsillitis of unknown cause, [Commission on Acute Respiratory Diseases], ★588
infected, penicillin for follicular tonsillitis, [Hopp] 133—ab
TOOTH: See Teeth
TORULOSIS of central nervous system, [Hassin] 1309—ab
TOXIC Goiter: See Goiter, Toxic
TOXICOLOGY: See Poisoning
TOXIN, antidotal property of Penicillin notatum filtrates, 33—E
TOXOPLASMOSIS, human, 306—ab; 852—E
choroiditis, a neutralizing antibody test for, [Johnson] 647—ab
in infants and children; probably no recurrence in repeated pregnancies, 970
TRACHEA: See also Laryngotracheobronchitis
bronchial drainage, 4 methods, [Foregger] ★1200
obstruction from congenital vascular ring, [Sweet] 1310—ab
tuberculosis, treatment, [Secretan] 430—ab
TRACHOMA, treatment, penicillin and sulfonamides, [Lavery] 67—ab
TRADE Hazard, Poisoning, etc.: See Industrial Diseases; Industrial Health, etc.
Unions: See Industrial Trade Unions
TRAFFIC Regulations: See Automobiles
TRAILER Camps: See Automobiles
TRAINS: See Railroads
TRANSFUSION: See Ascites; Blood Transfusion
TRANSPLANTATION: See Grafts (cross reference); Myocardium; Tendons; Tumors
TRANSPORTATION: See Automobiles; Aviation; Railroads; Ships; Traveling
of Sick and Wounded: See Ambulances
TRANSTHORACIC Vagotomy: See Nerves
TRANSURETHRAL Resection: See Bladder, paralysis
TRAPPER'S Preparation for Sinus, 264—BI
TRAUMA: See also Accidents; Burns; Fractures; Wounds; Medicolegal Abstracts at end of letter M; under names of specific organs and diseases as Brain; Head; Legs; Neuroma; Osteoporosis; Paraplegia; Pneumonia
TRAUMA—Continued
Electric: See Electric shock
fibrinolysis in, [Macfarlane] 805—ab
Industrial: See Industrial Accidents
International Congress for Traumatology, Sept. 1948, 1300
protest against injury in airplane accidents, [Behnke] ★455
Shock: See Shock, traumatic
thrombophlebitis and, 280
TRAVELING: See also Aviation; Railroads; Ships
immunizations for Kenya Colony, 434
inoculation of intending travelers against yellow fever, 643
TRAXO and Fruitola, 422—BI
TREATMENT: See Therapeutics
TREMOR, head, cataract surgery in patient with, 278
TRENCH Mouth: See Angina, Vincent's
TREPONEMA Pallidum Infection: See Syphilis pallidum, penicillin resistance to, acquired, 1282—E
Pertenue Infection: See Frambesia
TRICHINOSIS, epidemic, in Boars District, [Wird] 968—ab
in Massachusetts, [Ober] 965—ab
in New York City, [Shookhoff] 720—ab
serologic and skin tests in, [Roth] 968—ab
TRICHOMONAS hominis and diarrhea, 145
prostatitis, 733
TRICUSPID VALVE, bacterial endocarditis, [Karotkin] 139—ab
TRIDIONE: See Trimethadione
TRIETHYLENE glycol for disinfecting purposes, 696—E
TRIMETHADIONE (tridione), N.N.R., (description) 320; (Abbott) 320
treatment of epilepsy, [Lennox] 130—ab
TRIMM Vacuum Tube Hearing Aid, 542
TRINITROPHENOL (picric acid) stain of hair, removing, 734
TRIODE, (motion picture review), 802
TROOPS: See World War II
TROPICAL DISEASES: See also Tropical Medicine; and under names of specific diseases as Malaria; Schistosomiasis; Sprue; Yellow Fever; etc.
acne, [Novy] 889—ab
eosinophilia or pulmonary acariasis, [Hall] 967—ab
in veterans, [Sapero] 966—ab
studies, Ohio, 116
syphilis reaction (false positive) after, 73
treatment, melarsen oxide, [Payne] 893—ab
Typhus: See Tsutsugamushi Disease
Ulcer: See Leishmaniasis
TROPICAL MEDICINE: See also Tropical Diseases
American Journal of Tropical Medicine, (Dr. Craig resigns as editor) 794
Naval School of Tropical Medicine, Guam, 331
research Institute, Liberia, 192
TROPICS, efficacy of insecticidal sprays in aircraft, [Garnham] 140—ab
deterioration from living in, 1216—E
TRUBEK Fellowship: See Fellowships
TRUDEAU Revival in Japan, 52
TRUMAN, HARRY S., health program and social security, 180—E; 184—OS
designates May 1 Child Health Day, 1219—OS
President's Reorganization Act, 112—OS
rests on advice of physician, 871—OS
scientists thanked for wartime research, 327—OS
streptomycin controls continued, 482—OS
TRUNCUS arteriosus in infancy, [Taussig] 1303—ab
TRUST, medical A. M. A. as, first organized attack on, [Fishbein] ★761
TRYPANOSOMA cruzi, cancerolytic substance: Kiu, 111—22: [Kituvea] 1038—ab
TSUTSUGAMUSHI DISEASE, differentiate from rickettsialpox, [Greenberg & others] ★904
incidence in U. S. Army, 1942-1945, [Sadusk] ★1193
TUBAL Pregnancy: See Pregnancy ectopic
TUBE: See Catheterization; Duodenal Tube; Endotracheal Tube; Vitallium tube
TUBERCLE BACILLUS, detection by fluorescence technic, [Clegg] 68—ab
growth, streptomycin retards, [Corper] 207—ab
vole, injection in tuberculous persons, [Cameron] 429—ab
TUBERCULIN reactors, [Dash] 63—ab
reactors, calcifications in spleen in histoplasmin and, [High] 804—ab
skin reactions to, [Civelra] 503—ab
Test: See Tuberculosis, case finding
TUBERCULOSIS: See also Tuberculosis of Lung; under names of specific diseases and organs
board, U. S. Army air base hospitals taken over by, Fla., 791
case finding, chest x-ray surveys in Dachau concentration camp, [Platt] 65—ab
case finding, countywide chest x-ray service, Ind., 115
case finding, "personal equation" in interpreting chest roentgenogram, 399—E
case finding, roentgen technics compared, [Kovnat] 963—C
case finding, tuberculin testing, [Dash] 63—ab
TUBERCULOSIS—Continued
case finding, x-ray and photofluorographic methods compared, [Birkelo & others] ★359; 399—E
case register, Pa., 116; 956
complications, renal tuberculosis, [Ustvedt] 1318—ab
conference, N. Y., 707
congenital, aspiration type, [Pagel] 141—ab
control, Italy, 880
control problem, symposium, Chicago, 1023
control program, Chicago, 637
control program, expanded, New York, 256
control program, Richland County, S. C., 1229
control project, Maywood-Melrose Park Health Center Committee, 1163
diagnosis, sarcoidosis, [Cameron] 207—ab
hospitals, ★1066; ★1071
immunization, BCG, conference on, by USPHS, 1158—E
immunization, BCG, in hospitals and sanatoriums, [Ferguson] 889—ab
immunization, BCG, Norway, 1167; [Hertzberg] 1247—ab
immunization, BCG, program, N. Y., 637
immunization, BCG, skin reactions to, [Civelra] 503—ab
in captive wild birds, relation to diet, [Ratcliffe] 888—ab
in children, Swedish Red Cross home for, 712
in medical students, hazard, [Morris] 62—ab
in U. S., statistics, 698—E
in University students, Porto Alegre, 714
incidence in Europe, alarming spread, 947—OS
incidence, survey in 73 locations, Nebr., 490
industrial survey, Chicago, 489
infectious granulomatous lesions of cervix, [Guerriero & others] ★832
influenza vaccine, advisable to use? 1174
luposa, vitamin D_2 and calcium for, [Hermans] 504—ab
malignant primary, of adults, [Dufourt] 141—ab
National Association for Prevention of, Great Britain, 709
National Tuberculosis Association director of research: Dr. Esmond Long, 564
Pan American Congress on, 563
patients, inject vole tubercle bacilli in, [Cameron] 429—ab
patients, station of reeducation and apprenticeship of, 263
primary and adult, relationship between, [Ustvedt] 67—ab
psychology of patient, [Day] 428—ab
treatment, streptomycin, [Hinshaw] 269—ab; 1234
Trudeau festival in Japan, 52
Vaccination: See Tuberculosis, immunization
TUBERCULOSIS OF LUNG (pulmonary tuberculosis): See also Bronchus tuberculosis
adult, apical predilection, Röder's theory, [Röder] 1237—C
artificial pneumothorax (extrapleural) in, [Reid] 651—ab
Case Finding: See Tuberculosis, case finding
clinical session, N. Y., 414
complications: cardiac lesions, 567
hematogenous, and silicosis, [Zollinger] 1038—ab
surgical treatment of tuberculous pleural empyema, [Harbitz] 142—ab
surgical treatment, revision thoracoplasty, [Hochberg] 804—ab
surgical treatment, lobectomy; pneumonectomy, [Sweet] 1310—ab
treatment, amphetamine sulfate, [Houghton] 805—ab
treatment, penicillin intrapleurally, [Callahan] 138—ab
treatment, streptomycin, [Pfuetze] 648—ab; [Sanford & O'Brien] ★691
TULANE University, (degree in public health) 561; (Dr. Matas gift to library) 561
TULAREMIA, primary pneumonia, streptomycin treatment, [Smith] 205—ab
TUMORS: See also under names of specific organs and types of tumors
amebic, intestinal tumors, [Silverman & Leslie] ★994
Brodie's, of breast, [Aiken] 207—ab
Chromaffin Cell: See Pheochromocytoma
clinic association meeting, Pa., 956
Malignant: See also Cancer; Sarcoma (cross reference)
malignant, eosinophilia in, [Isaacson] 1171—ab
malignant, mechanism of radiation effects, Barnard Hospital lecture, [Warren] ★462
malignant, vagina cell examination for, [Ayre] 205—ab
masculinizing (possible), 213
neurology, [Wilson & Rupp] ★509
registry, Holman's gift to establish, 192
transplanted, Besredka's theory of immunity developed to, 111-E; [Gross] 800—C
TURKISH National Medical Congress (9th), 1236
TWINS, retinoblastoma in, [Falls] ★171
TYMPANUM: See Ear
TYPHOID carriers, Mich., 335
complications, hepatobiliary, in childhood, [Sepulveda de Borquez] 1247—ab
treatment, Vi antigen, [Fernandez Brito] 1247—ab
vaccine given after flood, Ill., 1227

TYPHUS, diagnosis (differential) from rickettsialpox, [Greenberg & others] ★904
epidemics, localized in war prisoners in France, [Lemierre] 651—ab
in research workers and others, [Sadusk] ★1194
in U. S. Army following immunization: incidence; severity; etc., [Sadusk] ★1192
louse borne, ear symptoms in, [Merel] 1318—ab
murine, in rat and man, [Davis] 131—ab
Scrub or Tropical: See Tsutsugamushi Disease
serodiagnosis, [Sadusk] ★1198
U. S. of America Typhus Commission Medal: See World War II, Heroes
vaccine (Cox-type), efficacy, [Gilliam] 268—ab

U

UN: See United Nations
UNESCO: See United Nations
UNRRA: See United Nations Relief and Rehabilitation Administration
U. S. P.: See Pharmacopeia
ULCERS: See also Abscess; Colitis, ulcerative; Peptic Ulcer; Suppuration; under organ or region affected as Cornea; Genitals; Mouth
treatment, bacitracin, [Meleney & Johnson] ★675
treatment, 5-nitro-2-furaldehyde semicarbazone, [Downing & others] ★299; [Morin] 963—C
treatment of arteriosclerotic leg, 1320
treatment, powdered human blood cells, [Anderson] 885—ab
Tropical: See Leishmaniasis, cutaneous
Venereal: See Chancre
ULCUS Molle: See Chancroid
ULTRAVIOLET RAYS, radiation for air disinfecting purposes, council discusses, 936
Sensitivity to: See Light
UMBILICAL CORD, tetanus fatal to 3 infants from infected talc used on stump, 1031
UNCINARIASIS: See Ancylostomiasis
UNCONSCIOUSNESS: See Anesthesia; Sleep
UNDERGRADUATE Work: Students; etc.: See Education; Education, Medical; Schools, Medical; Students; Students, Medical; University
UNDERNOURISHED: See Starvation
UNDULANT FEVER: See Brucellosis
UNIONS: See Industrial Trade Unions
UNITED MINE Workers Health Fund (Reference Committee report), 36; [Dickinson] ★1285
UNITED NATIONS: See also World Health Organization
Educational, Scientific and Cultural Organization, Paris conference, 342
UNITED NATIONS RELIEF AND REHABILITATION ADMINISTRATION (UNRRA), funds, allocated to World Health Organization, 1231
health division closes, 638
UNITED STATES: See also American; Federal; National
Army: See Army; World War II
Cadet Nurse Corps: See World War II, nurses
Civil Service Position: See Physicians positions open for
Congress (80th), what's ahead for? [Miller] 555—ab
Congress, legislation before: See Laws and Legislation
Dept. of Health: See Health, U. S. Department of
Dept. of National Defense, single department urged, 185—OS
Dept. of Welfare, 180—E; 184—OS
employees health division of U.S.P.H.S., 409
employees, maternity leave for, 185—OS
Food and Drug Administration: See Food
Government, A. M. A. motion on dispersal of federal funds for control of cancer, 40
Government Control of Medicine: See Medicine, state
Government Hospital Building Program: See Hill Burton Bill
Government Hospitals: See Hospitals
Government positions, specialists wanted for, 48
Government's research program, 462—ab
Military Academy, courses in mental hygiene proposed for, 327—OS
Navy: See Navy
of America Typhus Commission Medal: See World War II, Heroes
of America Typhus Commission, members, typhus in, [Sadusk] ★1194
Pharmacopeia: See Pharmacopeia
Public Health Service: See Health
Veterans Administration: See Veterans Administration
War with: See World War II
UNIVERSITY: See also Education, Medical; Schools, Medical; under names of specific universities as Columbia; Tulane
hygiene, Congress of, Paris, 52; 118
National Conference on Health in Colleges (3rd), 1217—E
of California (grant for cancer research) 636
of Cambridge, (gift for research in geriatrics by Nuffield Foundation) 1234
of Colorado, (medical center), 1291

UNIVERSITY—Continued
of Illinois, [U. S. Army Mayo General Hospital leased to), 255; (research grants to), 878
of Iowa: See State University of Iowa
of Michigan, (teaching opportunity cooperative plan), 706
of Texas, (grants to medical branch) 1229
of Washington (clinical departments), 336
pentagon be used as college for veterans, 871—OS
Premedical Work: See Basic Science; Education, Medical, premedical; Students, Medical Professors: See Professors
Students: See Students; Students, Medical
UREA: See also Thiouracil
medium to differentiate Proteus and paracolon cultures, [Christensen] 136—ab
Nitrogen in Blood: See Blood urea
treatment of suppurations of external auditory meatus, [Williams] 428—ab
UREIDE of Mesoxalic Acid: See Alloxan
UREMIA, chronic, renal osteodystrophy, [Norman & others] ★771
treatment, peritoneal irrigation, [Fine] 426—ab; [Goodyear & Beard) ★1208
URETHRA, surgery, full thickness skin graft to repair in hypospadias, 970
Transurethral Resection: See Bladder paralysis
URETHRITIS, chronic, in women, [Burns] 966—ab
Gonococcic: See Gonorrhea
in girls, [Roen) 570
treatment, streptomycin, 855—E
URINARY SYSTEM: See also Bladder; Kidneys; Urethra
grain mite infestation, [Crance] 1243—ab
infection, streptomycin for, [Adcock & Plumb] ★579; [Pool & Cook] ★586; 855—E
infections, mandelic acid, sulfonamides, arsenicals, penicillin for, [Pool & Cook] ★584
surgery, atelectasis during, [Faulconer] 647—ab
URINATION: See Urine incontinence; Urine suppression
Inducing: See Diuresis
URINE, anthocyaninuria; can beets tint or color urine blood red? 1254
barbiturates, tests for, 279
fluoride excretion in alkylation plant workers, [Largent] 1309—ab
incontinence, enuresis: start and stop method of treatment, [Jahr] 197
incontinence in women, Göbell-Stöckel's operation, [Christensen] 736—ab
incontinence, new method of cervicocystopexy, 56
incontinence (vaginal), from fistulas, apparatus for control, [Castallo] ★244
Polyuria: See Diabetes Insipidus
Porphyria in: See Porphyria
Protein in: See Albuminuria
protease treatment of allergy, [Rhoads] 135—ab
Red: See Porphyria; Urine, anthocyaninuria
sodium chloride excretion, 146
Sugar: See also Diabetes Mellitus; Glycosuria
sugar, pseudoglycosuria from penicillin, [Boldyreff] 715—C
suppression, anuria; renal decapsulation and peritoneal dialysis for, [Reid] 503—ab
surface tension, hexylresorcinol effect on, [Inness-Brown] 1301—C
urobilinogen test of liver function (Watson's), [Mateer & others] ★913
UROBILINOGEN in Urine: See Urine
UROGRAPHY: See Pyelography
UROLOGY course at St. Peter's and St. Paul's hospitals, London, 118
complications in spinal cord injury, [Bumpus & others] ★366; (tidal drainage or irrigation in) [MacNeil] 1237—C
Hispano-Portuguese Congress (5th) 567
URTICARIA, bee sting, [Reed] 68—ab
penicillin, benadryl and pyribenzamine for, [Pillsbury & others] ★1255
penicillin, benadryl for, [Willcox] 428—ab; [Callaway] 891—ab
penicillin, procaine for, [Dressler & Dwork] ★849; (caution advised) [Waldbott] 1301—C
treatment, new synthetic antihistaminics (3015 and 3277), 960
UTENSILS: See Cooking and Eating Utensils
UTERUS: See also Placenta
adenomyosis, [Spatt] 129—ab
Adnexa: See Ovary; Oviducts
cancer (cervical), interstitial radon needles vs. x-rays via intravaginal cones for, [Taylor] 131—ab
cancer (cervical), local recurrence 18 years after radium therapy, [Covington] ★935
cancer, diagnosis by vaginal smear; [Meigs] ★75
cancer of corpus, [Taylor] 1313—ab
cancer, ratio in myoma, [Crossen] ★595
cancer, roentgen therapy, fracture of femoral neck after, [Kulseng-Hanssen] 574—ab
Cervix: See also Uterus cancer (cervical)
cervix, erosion or polyps, premenstrual bleeding, 214
cervix, infectious granulomatous lesions, [Guerriero & others] ★832

UTERUS—Continued
cervix mucosa, ectopic pregnancy in, [Schneider] 131—ab
cervix mucus, receptivity to spermatozoa, [Barton] 140—ab
cervix, syphilis, [Guerriero & others] ★834
changes in Besnier-Boeck-Schaumann's disease, [Engelhard] 70—ab
contraction and retraction in prolonged labor, [Odell & others] ★735
contraction (painful) during pregnancy, 214
Hemorrhage (functional): See Menstruation
hemorrhage (post-menopausal), pathologic findings in, [Cheek] 425—ab
hemorrhage, use of metreurynter in, 74
intrauterine respiration of fetus, [Windle & Becker] 125—C
intrauterine use of sulfanilamide, [Sadovsky] 890—ab
inversion (acute), [Spain] 727—ab
iodized oil injected into, venous intravasation after, [Bloomfield] 805—ab
Mucosa: See Endometrium; Uterus, cervix
tumors, myoma, radiation therapy, [Crossen & Crossen] ★593
UVEA, sarcomas, 1284—E
UVULA: See Palate

V

VACCENIC ACID: See Acid
VACCINATION: See also Immunization; under names of specific diseases as Herpes zoster; Parotitis, Epidemic; Rabies; Smallpox
autovaccination treatment of cancer, 111—E; [Gross] 800—C
BCG: See Tuberculosis, immunization
successful (1646) on troop ship, 183—E
VACCINE: See also Encephalomyelitis; Influenza; Plague; Rabies; Typhus; Whooping Cough
BCG: See Tuberculosis, immunization
Castaneda, 656
laboratory to make, Puerto Rico, 336
mouse brain, treatment of epidemic encephalitis, [Sabin] ★281
VACCINIA: See also Smallpox vaccination
virus, penicillin effect on, [Gohar] 651—ab
VAGINA: See also Vulva
cell examination for malignant growths, [Ayre] 265—ab
discharge, Bacillus subtilis in cultures, 1320
discharge (persistent) in child, 436
douches, 508
Fistula: See Fistula
Ramses Vaginal Jelly and Applicator, N.N.R., (Schmid) 1281
smear, diagnosis of uterus cancer, [Meigs] ★75
urinary incontinence, apparatus to control, [Castallo] ★244
VAGOTOMY: See Nerves
VALENTINE, WILLARD L., death, 1230
VALLEY Fever: See Coccidioidomycosis
ven der WIELEN, P., death, 1300
van RIJNBERK, G., retires, Netherlands, 712
VARICELLA: See Chickenpox
VARICOSE VEINS, trauma and thrombophlebitis, 280
treatment, interval suspension of distal stem of resected "blowouts," [Ostroff] 197—C
VARIOLA: See Smallpox
VARNISH, contact dermatitis from Japanese rifles, [Hinman] 132—ab
VASCULAR: See Blood Vessels
VASECTOMY will not prevent enlargement and cancer of prostate, 358
as contraceptive, effects, 1254
VAUGHAN, Victor, first editor of *Hygeia*, 1922, [Fishbein] ★929
VBEV, 422—BI
VEGECENE, Sea, 883—BI
VEGETABLES: See also Beets; Carrots
Beech-Nut, with bacon, 937
fats, value for growth, [Basu] 68—ab
VEINS: See also Blood Vessels
Caval: See Vena Cava
femoral, interruption in venous thrombosis, [Allen & others] ★1269
Fistula: See Fistula
graft-vitallium tube technic for arteriovenous fistulas, [Herlingman & others] ★666
Inflammation: See Thrombophlebitis
Injection into: See Injections, intravenous
intravasation of iodized oil after intrauterine injection, [Bloomfield] 805—ab
Portal: See Portal Vein
Pulmonary, Embolism: See Embolism
Thrombosis: See Thrombosis, venous
Varicose: See Varicose Veins
VELDEE, MILTON, explains National Institute of Health, 371
VENA CAVA, interruption of, in venous thrombosis embolism, [Allen & others] ★1268
VENEREAL DISEASE: See also Chancroid; Gonorrhea; Prostitution; Syphilis
committee on, 1903, [Fishbein] ★611
control conference by U. S. Army, Japan, 186
Control Council established by War Dept., 486
control, pamphlets by U.S.P.H.S., 1294
control, request of Swedish Medical Board, 712
control, Sweden help fight in Poland, 1030
control, USPHS annual report, 702
incidence vs. circumcision in Canadian Army, [Wilson] 1243—ab

VENEREAL DISEASE—Continued
increase, N. Y. C., 637
Iowa Committee for Study of, 954
lectures, N. Y. C., 190
legislation, Norway, 1167
Public Health Institute closes its doors, Chicago, 334
treatment center (rapid), transferred to state department, W. Va., 1294
U. S. Army medical officers attend venereology classes, 186
VENESECTION and hypertension, 1253
VERMONT-New Hampshire Physicians Service, 112—OS
VERRUCA plana juvenilis, 733
VERTEBRA: See Spine
VERTIGO: See also Syncope
aural, Meniere's syndrome, [Atkinson] 133—ab
camp, [Kullman] 70—ab
cause; treatment, 434
scurvy and, [Ohnell] 430—ab
VETERANS: See also American Legion; Veterans Administration
disabled, additional training under vocational rehabilitation act, 113
disabled, traffic regulations for car-driving amputees, 1219—OS
disabled, Walter Reed patients view "The Best Years of Our Lives," 46—OS
G. I. Bill of Rights: See G. I. Bill of Rights
Hospitals: See Hospitals
Medical: See Veterans, physician
Medical Care: See also Hospitals, veterans
medical care for families of, 484—OS
medical care, home town, 331
medical care program, Hawley stresses need of private hospitals in, 45—OS
medical care, those seeking urged to identify themselves, 948—OS
Pentagon be used for college for, 871—OS
Physician, A. M. A. Bureau of Information for: See A. M. A. Bureau of Information
Physician, Courses or Training for: See Education, Medical, graduate
physician, difficulty in securing hospital staff appointments, 45
physician, licensure and relocation (Joint Committee report), 43
physician, locations for practice of, 944—OS
physician, resident program for (Joint Committee report), 42
physician, Spokane County Society assists, 491
Physician Veterans of World War II ("Doc-Vets"), (protest deferment policy) 184—OS; (Dr. Arkinson heads) 1159—OS
physician, want hospitals to employ those with military service, 184—OS
tropical diseases in, [Sapero] 966—ab
widows may claim terminal leave pay, 329
women, 488
VETERANS ADMINISTRATION, additional training under Vocational Rehabilitation Act, 113
Board of Roentgenology, [Birkelo & others] *359; 399—E
contracts, A. M. A. resolutions on, 35
electroencephalography technicians needed, 113
Hospitals under Control of: See Hospitals, veterans
medical corps, A. M. A. resolution on A. M. A. fellowship of, 39
medical corps, establishment, (Joint Committee report), 44; 945—OS
medical reforms, Hawley criticizes Legion for opposing, 699—OS
medical research program (long range) by National Research Council, 1289
medical work perilled by lack of funds, 787—OS
nurses, advanced training for, 1289
osteopaths to serve in, 186
paraplegic centers, 1020
patients without service connected disability, 482—OS
personnel ceiling in, drive for economy results, 699—OS
residency training in neurology, 186
resident program for physician veterans (Joint Committee report), 42
streptomycin allocation increased, 787—OS
tuberculosis case finding, "personal equation" in interpreting chest x-rays, 399—E
U. S. Army officers lent to, 113
VI Antigen: See Typhoid
VINCENT'S Infection: See Angina, Vincent's
VINSON-Plummer syndrome: See Plummer
VIOFORM treatment of ameblasis, 1042
VIRGINIA, rural areas, medical facilities available, 251—OS
VIRILISM, possible masculinizing tumor, 213
VIRUS: See also Encephalitis, epidemic; Influenza; Myocarditis; Parotitis, Epidemic; Poliomyelitis; Vaccina
Formolized: See Parotitis, Epidemic
infections (human) of animal origin, [Meyer & Eddie] *822
infections, laboratory diagnosis, Chadwick lecture by Dr. Bedson, 1299
plant disease, Woods continues research on, 185—OS
Pneumonia: See Pneumonia, atypical primary
receptor gradient in red cells, [Burnet] 67—ab
VISCEROPTOSIS: See Splanchnoptosis
VISION: See also Eyes; Glasses; Ophthalmology
binocular, orthoptics, Council report, [Lancaster & Lancaster] *1211
fields of, changes in, confirmed by pathologic diagnosis, [Lyle] *517
Loss of: See Blindness
motor component of retinal stimuli, 713
Nearsighted: See Myopia
symptoms of psychosomatic disorders, [Harrington] *669
VITAL STATISTICS, birth rate, highest in 23 years, England, 261
birth rate, Russia, 713
birth rate, U. S. shows increase, 405—OS; 1219—OS; 1295
birth registration, record, Ill., 115
Death Rate: See also Accidents, fatal; Death, cause of; Infants, mortality; Maternity mortality; under names of specific diseases
death rate, official number, 192
death rate, USPHS annual report, 702
death rate, violent deaths in Cook County, Ill., 412
Netherlands, 56
VITALLIUM mold arthroplasty in old femur fractures, [Smith-Petersen] 1308—ab
tube, venous graft to repair arteriovenous fistulas, [Heringman & others] *666
VITAMINS, Bates Preparations, 264—BI
Class' Vitamin, Mineral and Herb Formula, 568—BI
Curley-Bu-T-Caps; Curley-Cal-Pans, 264—BI
Deficiency: See also under names of specific vitamins
deficiency, avitaminosis in Turkey, 1236
Energy Release from Food (motion picture review), 717
new, in butter: vaccenic acid, 1299
question of best animal feeds, effect on milk supply, 775—E
VREV, 422—BI
VITAMINS A and bone growth, [Mellanby] 1316—ab
cyteal a fragment or, 1235
Imported Sea Vegetables Vitaminized with Added Vitamin A, 883—BI
in liver impairment, [Mateer & others] *915
VITAMINS B COMPLEX: See also Acid, *p*-aminobenzoic; Acid, folic; Pellagra
deficiency in pregnancy, [Vilter] 206—ab
Huzzah Vitamin B_1 and B_2 Supplement, 422—BI
in liver impairment, [Mateer & others] *915
injection to determine circulation time, [Swenson] 424—ab
suppress estrogenic function in women, affect libido or hasten menopause? 1253
syrup, N.N.R., (Thompson) 619
Vita-Pure B-Complex Vitamins, 568—BI
B_1: See also Acid, nicotinic; Thiamine Hydrochloride
B_1, Beawun Vitamin B_1 Tablets, 568—BI
B_1 deficiency, sclerogenic cardiopathy from, [Bianchi] 430—ab
B_1, electrocardiographic changes due to inanition, [Forster] 730—ab
B_1 treatment of headache after spinal anesthesia, [Bazzocchi] 430—ab
B_2: See Riboflavin
B_6: See Pyridoxine
VITAMINS C: See also Acid, ascorbic
Deficiency: See also Scurvy
deficiency, effect on wound healing, [Wolfer] 1313—ab
dissolution of substance of teeth by lemon juice, 1218—E
treatment of traumatic shock, [Holmes] 649—ab
treatment of trench mouth and scurvy, [Scherman] 1036—ab
VITAMINS D, high potency, preparations, (Council discusses), 851
D_2 and calcium for lupus vulgaris, [Hermans] 504—ab
VITAMINS K: See also Menadione
Bouillaud's disease and, [Lutembacher] 1172—ab
circumcision of newborn (reply), [Rosenthal] 436
treatment in obstructive jaundice, [Snell] *1178
treatment (routine), before delivery, 970
VITAMINS P, capillaries resistance and, [Lalmiche] 141—ab
VIT-AN-MIN, 568—BI
VITA-PURE B-Compiex Vitamins, 568—BI
VIVISECTION: See Animal Experimentation
VOCABULARY: See Terminology
VOCATIONAL Rehabilitation: See Rehabilitation
VOICE: See also Speakers; Speech
artificial aids, where to obtain, 146
masculinizing tumor, 213
VOLUNTEERS to Aid Hospitals: See Nurses aides
VOLVULUS: See Colon
VOMITING: See also Motion Sickness
of Blood: See Hematemesis
postoperative, and sedatives, 810
VON'S Tablets, 568—BI
VULVA, ulcer, bacitracin for, [Meleney & Johnson] *677

W

WAGES: See also Income
A. M. A. resolution on Bituminous Coal Mine Wage Agreement, 35
nurses request higher pay, Sweden, 1030
salaries of junior hospital doctors, Norway, 797
Tax on: See Tax, Income
WAGNER-MURRAY-DINGELL Bill, reintroduced, 631—OS
WAKE Forest College: See Bowman Gray School
WALLACE, W. V., personal, 790
WAR: See also Military Medicine; Spanish American War; World War
Assets Administration, Sale of Surplus Supplies: See Medical Supplies, surplus
Casualties: See World War II
Heroes: See World War II, Heroes
Needy: See World War II, needy
Prisoners: See World War II, Prisoners
Veterans: See Veterans
Wounds: See World War II, wounds
WARD Helpers: See Hospitals, personnel; Nurses, aides
WARM SPRINGS Foundation: See Foundations, Georgia Warm Springs
WARTS: See Verruca
WASHINGTON Office: See American Medical Association
State Bureau, A. M. A. seal of acceptance to, 112—OS
University: See also University of Washington
University (St. Louis) (regional scholarships), 413; (course in hospital administration) 1163
WATER: See also Flood; Ice; Steam
etiology of poliomyelitis, [Scobey] 721—ab
fluorine in, safe level, 733
Leptospirosis canicola, [Baber] 140—ab
Metabolism: See also Dehydration
metabolism, disorder in hypertension, [Perera] 499—ab
Mineral: See Health resorts; Mineral water
Pollution: See also Sewage
pollution by rivers, (hearings on bill) 1219—OS; (Illinois) 1292
supply, Croton reservoir, Dr. Pallen accused of poisoning; A. M. A. resolution protesting action, 1865, [Fishbein] *24
supply, nitrates in well water, methemoglobinemia in infants, [Faucett] 271—ab
test in Addison's disease, [Levy] 136—ab
Therapeutic Use: See Hydrotherapy
transportation of mosquitoes by ships in old tires, [Pratt] 723—ab
WATSON'S urobilinogen test of liver function, [Mateer & others] *913
WEARING Apparel: See Clothing
WEATHER changes and eclampsia, [Sapelka] 894—ab
WEIGHT: See Body weight; Infants, Newborn; Obesity
WEIGHTS AND MEASURES, metric system, 1879, [Fishbein] *177
WEIL'S Disease: See Jaundice, spirochetal
WEIL-FELIX REACTION, specificity, 358
in typhus, [Sadusk] *1198
WEISKOTTEN, H. G., chairman of A. M. A. Council, 34—E
WELFARE, U. S. Dept. of, 180—E; 184—OS
WELL Water: See Water supply
WEN: See Steatoma
WERNICKE'S Encephalopathy: See Polioencephalitis
WEST, OLIN, field secretary, 1922, [Fishbein] *926; (made general manager, 1924) *935
President-Elect, resigns, 1012—E; 1016
WEST'S Imported Sea Vegetable Tablets, 883—BI
WEST VIRGINIA Cancer Society Contest: See Prizes
WESTERN RESERVE University, alumni, war service, 1164
WETTING AGENTS: See Detergents; Zephiran chloride
WHAYNE, T. F., personal, 329
WHEAT: See also Bread
germ, Hayden's Carmelized, 264—BI
WHISKY treatment of influenza in 1920, [Fishbein] *924
"WHITE PAPER": See National Health Service Act
WHOOPING COUGH, skin test reagent, standardized, [Felton] 892—ab
vaccine, [Waddell] 203—ab
vaccine, booster injections, [Kendrick] 268—ab
WILDE, CHARLES FENWICK, death, 492
WILDER Lecture: See Lectures
WINE of Cardui, 1915, [Fishbein] *836
WIRELESS: See Radio; Television
WOMAN'S AUXILIARY, A.M.A., established, 1922, [Fishbein] *928
A.M.A. resolution on, 38
COOKBOOK FOR HUNGRY DOCTORS sale to aid Freeman student loan fund, Pa., 877
WOMEN: See also Marriage; Maternity; Menstruation; Menopause
amount of clothing worn by, in 1888, [Fishbein] *315
in Medicine: See Nurses; Physicians, women

WOMEN— Continued
Public Health Education Committee of, 1910, [Fishbein] *762
war veterans, 488
Workers: See Industrial Health, workers
WOODS, ALBERT F., continue research in plant disease viruses, 185—OS
WOODWARD, W. C., A.M.A. Bureau of Legal Medicine, 1923, [Fishbein] *929; *931
WORDS AND PHRASES: See Terminology; Medicolegal Abstracts at end of letter M
WORK, HUBERT, presidential address of, 1922, [Fishbein] *927
WORK: See also Effort; Exercise; Industrial Health
Compensation for: See Wages
output and caloric intake, 322—E
The.apeutic Use: See Occupational Therapy
WORKMEN'S COMPENSATION: See Industrial Accidents; Medicolegal Abstracts at end of letter M
WORLD HEALTH ORGANIZATION, (Calderone heads Interim Commission) 117; (international epidemiologic reporting service by Interim Commission) 258; (outline of work) 405—OS; (constitution, USPHS annual report) 702; (constitution expected to be ratified) 788—OS; (Interim Commission meets March 31) 956; (participation of U. S. in) 1161; 1221—OS; (allocate UNRRA funds to) 1231
WORLD LEAGUE: See United Nations
WORLD WAR I (1914-1918), A.M.A. participation in, [Fishbein] *838; *839; *841; *842; *848
Veterans: See American Legion
WORLD WAR II (1939-1945), ameblasis in Americans in India, [Klatskin] 500—ab
atomic bomb effect at Hiroshima and Nagasaki, 1158—OS
atomic warfare, medical aspects, 1225
Casualties: See also World War II, Heroes, for names of physicians killed in action
casualties (battle), fatal pulmonary embolisms in, [Hamilton] 572—ab
casualties, death (sudden and unexpected) of young soldiers, 325—E; [Moritz] 721—ab
casualties (psychiatric), high incidence, [Hanley] 344—C
encephalitis (epidemic) in military personnel, [Sabin] *281
GI Bill of Rights: See GI Bill
Honorably Discharged: See subhead; Medical Officers
hospital (Kings County), dedicate memorial Plaque to 816 employees, 955
Killed in Action: See World War II, Heroes
libraries devastated by, periodicals and books needed, [Taylor] 345—C; [Kouwer] 715—C; 878
Medical Officers: See also Veterans, physician
medical officers, Airborne Medical Society formed, England, 261
medical officers, death while in service, 109—E
medical officers, list of released by Navy, 254; 333; 411; 635
medical officers, list of, released by USPHS, 1289
medical officers, list of, separated from service by Army, 188; 332; 410; 704; 952; 1021; 1226; 1290
medical officers (Navy), not allowed to resign; Captain Eaton's reply, 44
medical officers (125) released by Army to U.S.P.H.S., 46—OS
medical officers, released by U.S.P.H.S., number, (Joint Committee report), 45; 1289
Medical Officers, Returning to Private Practice: See Veterans, physicians
medical officers, separated from service by Army, statistics, 45
medical officers 3 or more years on Induction Examining Board, 335
medical officers, tribute to by Brig. Gen. Bliss, 481—E
needy, medical supply for, 1025
nurses, U. S. Cadet Nurse Corps, 110—E
nutrition in Switzerland, [Fleisch] 354—ab
Officers: See subhead; Medical Officers
Physicians: See also subhead: Medical Officers
Physicians, A. M. A. Bureau of Information for those Returning: See American Medical Association
physicians in civilian practice, 5,000 questionnaires from A. M. A. Committee, 480—E; [Dickinson] 548—ab; 550—ab
Postwar, UNRRA: See United Nations Relief and Rehabilitation Administration
prisoners (American), pellagra in, Philippines, [Lewis] 501—ab
prisoners, brutalities by Germans, Dr. Ivy's report, 35; [Wertham] 645—C
prisoners, caloric intake and industrial output, 322—E
prisoners, camp vertigo, [Kullman] 70—ab
prisoners, chest surveys in Dachau camp, [Platt] 65—ab
prisoners, nutritional amblyopia in those liberated [Bloom] 62—ab
prisoners, typhus epidemics in France, [Lemierre] 651—ab
WORLD WAR II—Continued
schistosomiasis japonica in Leyte reoccupation, [Winkenwerder] 1242—ab
selectees, physical examination in final months, 854—E
service men's Christmas mail lost at sea, 486
Switzer (M. E.) Certificate of Merit to, 48
Syphilis in: See subhead: Venereal Disease
tongue changes in British troops not due to deficiency disease, [Smith] 68—ab
tonsillitis and pharyngitis, [Commission on Acute Respiratory Diseases] *588
tropical deterioration in troops, 1216—E
tropical disease, positive syphilis test after, 73
tsutsugamushi disease in U. S. Army, [Sadusk] *1193
typhus in U. S. Army after immunization, [Sadusk] *1192
vaccinations on a troop ship, 183—E
venereal disease, syphilis in 1400 soldiers, penicillin for, [Sternberg & Leifer] *1
Veterans: See Veterans
Western Reserve alumni service in, 1164
wound shock, [Stewart] *216
wounded, replacement of blood [Snyder] *219
wounds of ventricles of brain, [Pitts] 1240—ab
wounds, traumatic chylothorax resulting, [Berry] *319
wounds (open), bacteriology of, [Rustigian & Cipriani] *224
WORLD WAR II, HEROES
Abbett (A. L.), Bronze Star, 634
Anderson (J. B.), Legion of Merit, 330
Anderson (R. D.), Navy Commendation Ribbon, 950
Asbury (C. W.), Bronze Star, 487
Baird (C. A.), Legion of Merit, 634
Barnard (L. B.), Legion of Merit, 487
Barnes (R. H.), Bronze Star, 487
Barton (W. E.), Legion of Merit, 487
Bloomberg (W.), Legion of Merit, 252
Bollbaugh (T. B.), U. S. Typhus Commission Medal, 1162
Bookout (A. C.), killed in action, 711
Boucher (H. E.), Legion of Merit, 1224
Brett (J. D.), Legion of Merit, 1162
Brewer (J. L.), Legion of Merit, 950
Brislen (A. J.), Army Commendation Ribbon, 47
Brown (A. K.), Legion of Merit, 47
Buckhold (W. W.), killed in action, 340
Byrne (W. A.), Bronze Star, 331
Callahan (J. J.), Legion of Merit, 330
Campbell (P. A.), Legion of Merit, 486
Canning (A. J.), Oak Leaf Cluster to Legion of Merit, 47
Carroll (F. B.), Legion of Merit, 330
Ciccone (R.), Army Commendation Ribbon, 1162
Comstock (J. A.), Bronze Star, 634
Cook (W. L., Jr.), Legion of Merit, 487
Corr (W. P.), Legion of Merit, 486
Craige (B., Jr.), Army Commendation Ribbon, 1224
Cromartie (W. J.), Legion of Merit, 487
Denny (E. R.), Legion of Merit, 1224
Dieuaide (F. R.), Legion of Merit, 252
Eisendorfer (A.), Army Commendation Ribbon, 1019
Elkins (C. W.), Legion of Merit, 634
Eschenbrenner (J. W.), Legion of Merit, 1020
Fabing (H. D.), Legion of Merit, 1288
Farnham (R. K.), Legion of Merit, 487
Ferderber (M. B.), Legion of Merit, 1162
Ferenbaugh (T. L.), Legion of Merit, 409
Fielding (R. E.), Bronze Star and Gold Star, 1225
Friedman (N. B.), Army Commendation Ribbon, 1288
Fulton (J. R.), Legion of Merit, 560
Gaskill (R. C.) Legion of Merit, 1224
Goldman, (J. L.), Army Commendation Ribbon, 252
Gordon, (J. E.), Legion of Merit and U. S. Typhus Commission Medal, 874—OS
Greeley (D. M.), U. S. of America Typhus Commission Medal, 1019
Greenwell (A. W.), Legion of Merit, 486
Guidotti (F. P.), Legion of Merit, 330
Guttmacher (M.), Legion of Merit, 487
Ham (T. H.), Legion of Merit, 487
Harbison (S. P.), Legion of Merit, 487
Hargreaves (J.), Bronze Star, 1288
Heaton (L. D.), Oak Leaf Cluster to Legion of Merit, 634
Heinemann (A. D.), Army Commendation Ribbon, 409
Hennessy (H. R.), Bronze Star Medal, 330; (correction) 487
Henze (C.), Legion of Merit, 1020
Hines (L. W.), Legion of Merit, 1225
Hodges (R. G.), Legion of Merit, 950
Horgan (E.), Legion of Merit, 1224
Ingham County Medical Society members cited for volunteer service, Mich., 256
Kirk (N. T.), Legion of Merit, 252
Kostrubala, (J. G.), Army Commendation Ribbon, 559
Lamy (J. E.), Silver Star, 634
Laudicina (A. P.), killed in action, 959
Layne (J. A.) Legion of Merit, 409
Leifer (W.), Legion of Merit, 559
WORLD WAR II, HEROES—Continued
Leone (G. E.), Legion of Merit, 1018
Little (A. R.), Air Medal, 1020
Long (A. P.) Legion of Merit, 252
Long (F. B., Jr.), killed in action, 120
Long (J. O.), killed in action, 711
LoPinto (A. F.), Navy Commendation Ribbon, 48
Lovelace (W. R., II), Legion of Merit, 1162
Lowry (R. H.), Legion of Merit, 1224
Luck (J. Y.), Legion of Merit, 559
McAfee (L. B.), Legion of Merit, 1018
McDonough (F. E.), Legion of Merit, 1288
McLane (A. D.), Legion of Merit, 1162
Meade (R. H.), Legion of Merit, 634
Merkel (E. E.), Bronze Star, 874
Morton (P. H.), Air Medal, 1225
Most (H.), Legion of Merit, 874; (correction) 1020
Murray (J. M.), Legion of Merit, 1288
Nagler (B), Army Commendation Ribbon, 409
Paullin (J. E.), Medal for Merit, 950
Payne (B. F.), Army Commendation Ribbon, 1224
Pennington (W. H.), Legion of Merit, 1019
physicians killed in action, statistics, 109—E
physicians, USPHS officers (5) killed in service, 702
Pickard (K.), Bronze Star, 634
Prather (H. L.), Legion of Merit, 1019
prisoners, USPHS officers, 702
Robinson (P. I.), Oak Leaf Cluster to Legion of Merit, 1224
Romansky (M. J.), Legion of Merit, 1020
Savage (H. W.), Legion of Merit, 330
Shapiro (M. A.), Silver Star and Oak Leaf Cluster to Silver Star, 1288
Skelton (R.), Legion of Merit, 486
Smadel (J. E.), U. S. of America Typhus Commission Medal, 1224
Spruit (C. B.), Distinguished Service Medal, 634
Steinberg (S.), Army Commendation Ribbon, 47; (correction) 487
Streit (P. H.), Legion of Merit, 874—OS
Streuter (L. W.), killed in action, 120
Trumbull (R. A.), Legion of Merit, 330
Tucker (E. W.), Bronze Star Medal, 1162
van Ravenswaay (A. C.), Legion of Merit, 559
Verdel (L. F.), Legion of Merit, 1019
von Pohle (C. L.), Legion of Merit, 1019
Waterous (W. H.), Legion of Merit, 1288
Whayne (T. F.), U. S. of America Typhus Commission Medal, 1019
Williams (R. P.), Legion of Merit, 1162
Wollack (A. R.), Soldier's Medal, 330
Woodland (J. C.), Legion of Merit, 486
WOUNDED: See World War II, wounded
Transport of: See Ambulances
WOUNDS: See also Accidents; Burns; Trauma; under specific organs and regions
bacteriology of open wounds, [Rustigian & Cipriani] *224
healing, animal tissue extracts effect on, [Hoffman] 720—ab
healing, chlorophyll for, [Bowers] 1240—ab
healing in vitamin C deficiency, [Wolfer] 1313—ab
healing of open pilonidal wound, [Blalsdell] *916
infected, bacitracin for [Meleney & Johnson] *677
penetrating, of knee, [Hampton] 349—ab
shock, [Stewart] *216
suppuration, pabulum theory, [Lyons] *215
Suture of: See Suture
treatment, blood replacement, [Snyder] *219
treatment, sulfonamides, penicillin, streptomycin, [Lyons] *215
treatment, symposium on, [Lyons] *215; [Stewart] *216; [Snyder] *219; [Rustigian & Cipriani] *224; (discussion) 229
War: See World War II
WRIST injuries in elderly, [Griffiths] 806—ab
WRITING: See also Articles; Books; Journals; Terminology
American Physicians' Literary Guild, 257; 1165
Essay Contest: See Prizes
Prescriptions: See Prescriptions

X

XANTHOMATOSIS: See Niemann-Pick Disease
X-RAYS: See Roentgen Rays

Y

YALE University, (graduate program successful) *253; (receives Klebs Library of Medical History) 334; (Summer School of Alcohol Studies) 636
YAWS: See Frambesia
YELLOW FEVER and plague, 563
vaccination of intending travelers, 643
YOUTH: See Adolescence

Z

ZEIT Lecture: See Lectures
ZEPHIRAN Chloride, N.N.R., (Winthrop) 179
ZONA ophthalmica: See Herpes Zoster, ophthalmicus
ZONDEK-Aschheim Test: See Pregnancy
ZOSTER: See Herpes Zoster

AUTHOR INDEX

In this Index are the names of the authors of articles which have appeared in THE JOURNAL, the names of those who have read papers before Societies as published in THE JOURNAL and those whose articles have been abstracted in the Current Medical Literature Department. The * preceding the page reference indicates that the article appeared in full in THE JOURNAL.

For subject index see page 1323.

A

Aarseth, S., 968
Abbe, D., 570
Abbott, K. H., 723
Abernethy, T. J., *588
Abramowicz, I., 352
Abrams, I., 886
Abramson, H., 570
Acevedo Olvera, A., 1317
Adams, H. D., 650
Adcock, J. D., *579
Adler, H. F., *373
Adriani, J., 129
Agin, L. J., 1312
Aiken, D., 207
de Ajuriaguerra, 806
Aldrich, C. A., 1314
d'Allaines, F., 729
Allen, A. W., 132, *1268
Allen, F. M., *377
Almkiov, J. H., 570
d'Alotto, V., 806
Altemeier, W. A., 1036
Alture-Werber, E., 61, 62
Alvarez, C., 1248
Alves, W., 69
Amos, F. B., 124
Amspacher, W. H., 571
Amyot, R., 502
Andelman, M. B., 65
Anderson, H. C., 135
Anderson, M. W., 885
Anderson, S. G., 67
Andreyev, S. V., 431
Andrus, W. D. de W., 720
Angevine, D. M., 572
Appelgren, A., 895
Arho, A. P., 142
Armas-Cruz, R., 1247
Armstrong, C., 272
Armstrong, W. D., 573
Astwood, E. B., 500
Atkinson, A. J., *373, 1307
Atkinson, M., 133
Atwell, R. J., 205
Aufranc, O. E., 1308
Aycock, T. B., *1258
Ayre, J. E., 205

B

Baber, M. D., 140
Bachmann, G., 202
Badger, G. F., *588
Baer, R. L., *293
Bagnall, D. J. T., 428
Bailey, O. T., 721
Balthazar, E., 893, 893
Baltz, J. I., *909
Bancroft-Livingston, G., 894
Bang, F. B., 132
Barber, F., 1315
Barefoot, S. W., 720, 891
Bargen, J. A., 890
Barltell, A. L., 1314
Barkan, O., *526
Barker, C., 549
Barker, N. W., 885
Barnes, R. W., *456
Baronofsky, I. D., 1036
Barrera, S. E., 500
Barron, D. H., 207
Barrow, D. W., 63
Bartels, E. C., 893
Barton, M., 140
Barlstra, H. K. G., 1317
Bashatli, A., 651
Bass, H. E., 499
Bastable, S., *771
Basu, K. P., 68
Bauer, W. W., 548
Baylin, G. J., 1313
Bayliss, 350, 725
Bayrd, E. D., *147
Bazzocchi, G., 430
Beard, D. E., 139, *1208
Beard, J. W., *588
Beard, R. R., 720
Beck, A. C., *78
Beck, G. M., 726
Becker, E. R., 202
Becker, R. F., 125
Becker, W. F., 1313
Beecham, C. T., 425
Beek, C. H., 895
Beer, K., 967
Behnke, A. R., *450
Belerwaltes, W. H., 570
Belart, W., 141
Bell, G. O., 893
Bell, J. C. R., 208
Ben-Asher, S., 348
Berczeller, A., 804
Berger, K. E., *600
Bergström, E., 1318
Berman, J. K., 348
Berman, L., 127
Berry, R. L., 66
Berry, W. H., *319
Bersack, S. R., 131
Best, M. M., 348
Bezerra, D. A., 893
Bianchi, A. E., 430
Bianco, A. A., 272
Bierl, J., 503
Bierman, H. R., *522
Bigby, M. A. M., 727
Bigger, I. A., *513
Biggs, R., 805
Birkelo, C. C., *359
Birnkrant, W. B., 720
Bishop, L. K., *1277
Bjørnstad, R., 1248
Black, D. A. K., 352
Black, G. H. B., 1316
Blackman, S., 723
Blain, A., 134
Blair, D. M., 69
Blaisdell, P. C., *916
Blakely, E., 426
Blalock, A., 426
Blankenhorn, M. A., 137
Blegen, H. M., *1207
Blood, D. W., 499
Bloom, S. M., 62
Bloomfield, A., 805
Bluestone, E. M., *1051
Bohne, W., *296
Bohrod, M. G., 885
Boisvert, P. J., 132
Boldyreff, E. B., 715
Boots, R. H., *752
Borisova, E. I., 431
Borman, M. C., *394
Borst, J. R., 968
Bottone, J. J., 1311
Boulin, R., 1038
de Bourgraaf, J. E., 730
Bowers, W. F., 1240
Bowman, M. C., 348
Boyd, E. M., 716
Boyd, H. B., 1308
Boyd, M. F., 135
Brachetto-Brian, D., 1317
Bradley, W. F., *459
Bradshaw, H. H., 348
Branday, W. J., 888
Brannon, E. S., 424
Brazier, M. A. B., 721
Brian, E. W., 351
Bridge, E. M., 271, 570
Bridge, E. V., 1308
Bridges, W. C., *16
Broadbent, T. R., 204
Brockman, N. W., 889
Bromberg, Y. M., 890
Bronson, L. H., 500
Brosnan, J. T., 351
Broster, L. R., 68
Broun, G. O., *178
Brouwer, S. W., *909
Browder, J., 272
Brown, A., 1315
Brown, H. W., 268
Brown, J. B., 720
Brown, M. J., 1241
Brown, R. H., *661, 721
Brown, S., 1245
Brown, W. T., 207
Brownlee, G., 1246
Brunel, H., 429
Bryce, L. M., 805
Buer, A. W., 1317
Buerki, R. C., 782
Bumpus, H. C., Jr., *366
Bundesen, H. N., 886
Burk, L. B., Jr., 1314
Burke, F. G., 892
Burkhardt, W. L., *373
Burks, C. S., 202
Burlingame, C. C., *971
Burnet, F. M., 67, 67, 140
Burnett, C. W. F., 1037
Burns, E., 966
Bushby, S. R. M., 574
Bussell, L. J., 728
Butt, A. J., 966
Butterworth, S., 885

C

Cabello, J., 1247
Calhan, R. J., 134
Calkins, E., 136
Callahan, F. F., 138
Callahan, W. P., Jr., 724
Callaway, J. L., 891
Cameron, C., 207, 429
Cammaert, C. A., 968
Camp, J. D., 1171
Campbell, A. S., 349
Campbell, K. N., 66
Campos, J. M. C., 730
Cannon, B., 720
Cardoso, L. E., 652
Carpenter, G. K., 349
Carroll, W. W., 1313
Carruthers, L. B., 1246
Case, P. H., 722
Casey, A. E., 65, 886
Caso, E. K., *169
Cassells, D. A. K., 352
Castallo, M. A., *244
Castex, M. R., 806
Cattell, R. B., 273
Cave, H. W., 132
Certonciny, A., 1317
Chamberlain, W. E., *359
Chang, G. C. T., 131
Chapman, W. P., *741
Cheek, D. B., 425
Chevallier, P., 353
Chiavacci, L. V., 1306
Chin, H., *445
Chisholm, T. C., 134
Christensen, L. Ø., 730
Christensen, W. B., 136
Christie, A., 202
Chrysanthis, K., 354
Chu, L. W., 131, 571
Cieslak, A. K., 722
Cipriani, A., *224, 1306
Civeira, F., 503
Clagett, O. T., 138
Clark, E. G., 425
Clark, K. B., 1308
Clark, W. M., 573
Clarke, G. H., 570
Clarke, W., 894
Clavel, C., 895
Clayton-Jones, E., 1316
Clegg, J. W., 68, 208
Cleland, G., 352
deClercq, F., 729
Cluer, E. H., 274
Coggeshall, L. T., 1238
Cohen, A., *749
Cohen, M. J., 503
Cohn, M. L., 207
Cole, L. M., 720
Collins, E. N., 1171
Collins, S. D., 649
Colp, R., 890
Colvert, J. R., *909
Comroe, J. H., Jr., 886
Conn, J. W., 128
Cook, E. N., *584
Cook, S. F., 1308
Coombs, F. S., 61
Cooney, E. A., 203
Cooper, O., 865
Cope, O., 426
Corper, H. J., 207
Corrigan, F. L., 805
CoTui, 272, 1312
Council, F. E., 128
Covington, E. E., *935
Cowan, F. A., 1305
Cox, H. R., *820
Crafoord, C., 138
Cramer, F. J., 133
Crance, A. M., 1243
Crawford, T., 728
Cressy, N. L., *588
Crile, G., Jr., 648
Crosby, R. C., 203
Crossen, H. S., *593
Crossen, R. J., *593
Crossman, L. W., *377
Cruthirds, A. E., 131
Culbertson, J. T., 269
Curbelo Hernandez, A., 1247
Curphey, T. J., *1062
Curry, J. J., *243
Custer, W. C., 66
Czebrinski, E. W., 64

D

Dahl-Iversen, E., 142
Dalgaard, J. B., 806
Dameshek, W., 1306
Damiani, C. R., 1036
Daniels, W. B., 888
Darling, D., 501
Dash, H. H., 63
Davidsohn, I., 345
Davies, D. T., 728
Davis, C. B., Jr., *461
Davis, D. E., 131
Davis, D. R., 966
Davis, G. L., 860
Davis, J. E., 425
Davis, H. A., *663
Davis, W. D., 129
Davis, W. S., 1310
Davison, T. C., 1245
Davison, W. T., 887
Dawson, E. K., 207
Day, G., 428
DeBakey, M. E., 1036
Debray, J. R., 895
Decoursey, E., 350
DeLamater, E. D., 1303
Denize, A., 804
Denolin, H., 729
Denstad, T., 1038
DeOreo, G. A., 720
Derbyshire, R. C., 1313
Desmarais, M. H. L., 67
deTakats, G., *441
Deuel, H. J., Jr., 1304
de Wardener, H. E., 1246
Dhont, J., 1317
Dickinson, F. G., *183, 548, *1014, *1222, *1285
Dickson, J. A., 138
Dillon, J. B., *829
Dingemanse, E., 730
Dingle, J. H., *588, 888
Dingwall, J. A., 720
DiPalma, J. R., 127
Dirkse, P. R., 499
Dixon, C. F., 206
Doan, C. A., 128
Dodd, K., 886, 893
Dodds, E. C., 352
Domaniq, E., 504
Donaldson, G. A., *1268
Donnelly, B. A., 649
Dostrovsky, A., 269
Doty, E. J., 1241
Doughty, J. F., 862
Dowling, H. F., 270, *657, 1171, 1309
Downing, J. G., *299
Downs, R. A., 499
Dragstedt, L. R., 1168
Drake, J. R., 134
Drake, T. G. H., 647
Dressler, S., *849
Drucker, A. P., 721
Dubbs, A. W., *749
Dudgeon, J. A., 274
Dufourt, A., 141
Dumas, J., 895
Duncan, C. J., 803
Dundon, C. C., 273
Dunn, J. H., 206
Dunner, L., 428
Duprez, A., 729
Durieu, H., 729
Dutton, L. O., 965
Dwork, R. E., *849

E

Eagle, H., 136
Eaton, M. D., 1303
Echlin, F. A., 205
Eddie, B., *832
Edwards, E. W., 724
Eerland, L. D., 431
Ehrlich, J. C., 571
Eldering, G., 268
Ellenberg, M., 424
Ellett, E. C., 1032
Ellis, F. A., 1244
Emmett, J. L., 206
Enders, J. F., 350, 501
Engelhard, J. L. B., 70
Ensign, P. R., 271
Ensor, C., 202
Erf, L. A., 62
Ericksen, C. C., *616
Ershoff, B. H., 1304
Escalle, L. J., 729
Espersen, T., 142
Estren, S., 1306
Evans, E. I., *513
Evans, H. S., 723
Evans, W. F., 424
Evoy, M. H., *441

F

Faber, L. A., Jr., 968
Faber, M., 70, 652
Fallon, J., 351
Falls, H. F., *171
Farinas, P. L., 272
Farmer, C. J., 1313
Fasciolo, J. C., 61
Fashena, G. J., 893
Faucett, R. E., 572
Faucett, R. L., 271
Faulconer, A., Jr., 647
Faust, E. C., 201
Fein, G., 1305
Feinberg, A. R., 1309
Feinberg, S. M., 269, 1309
Feinstein, H. R., 131
Feldman, F., 500
Feldman, W. H., 269
Feller, A. E., *588
Felsovanyi, A., 425
Felton, H. M., 892
Ferguson, R. G., 889
Fergusson, J. D., 69
Fernandes, J. S., 893
Fernandez Brito, C., 1247
Fetter, N. R., 137
Fiehrer, A., 353
Figge, F. H. J., *105
Filley, G. F., 270
Finch, C. A., 61
Findlay, C. W., Jr., 1310
Findlay, G. M., 69
Fine, J., 426
Fink, I., 804
Finland, M., 426
Fishbein, M., *23, *100, *174, *235, *310, *383, *454, *533, *605, *681, *761, *836, *923
Fishbein, W. I., 65, 836
Fisher, S., 1305
Fleisch, A., 354
Fleischman, R., 136
Flood, J. M., 891
Florey, M. E., 727
Florman, A. L., 128
Flynn, J. M., 61
Fodden, J. H., 140
Foley, G. E., 1311
Foltz, T. P., 891
Fontaine, R., 429

Ford, R., 721
Foregger, R., *1200
Forestier, J., 1317
Forgarasi, D., 1248
Forrester, J. S., 892
Forshaw, H. W., 429
Forster, E., 429
Forster, R., 730
Foster-Carter, A. F., 68
Fowler, E. P., Jr., *87
Frada, G., 354
Francis, N., 803
Frank, G., 804
Frank, H. A., 426
Frank, L. L., 804
Frater, K., 69
Fredriksen, W., 208
Freed, S. C., *369, 1032
Freeman, H., 140
Freeman, W., 891
Freyhan, F. A., 1032
Friedlaender, S., 269, 1309
Friedman, N. B., 200
Frisk, A. R., 574, 1246
Fuentes Acevedo, Z., 1247
Furcolow, M. L., 1245
Furtado, D., 208
Furth, J., 268

G

Gaines, T. R., 647
Gajdos, A., 574
Galgaard, J. R., 1318
Gallmard, J. E., 1172
Gallagher, J. P., 272
Galmiche, P., 141
Gammon, G. D., 886
Gardiner-Hill, H., 68
Garlepy, L. J., 1169
Garnham, P. C. C., 140
Gauss, H., 719
Geiger, A. J., 135
Geiger, J., *392
Gelfand, M., 651
Gelinas, H., 502
Gellhorn, A., 269
Geoghegan, F., 727
George, C. W., *754
George, I. L., 1308
Gerle, B., 142
Gibson, H. J., 67
Gibson, T. E., *1255
Gillespie, J. B., 886
Gilliam, A. G., 268
Giraud, P., 353
Glenn, F., 720
Glover, R. E., 274
Glover, R. P., 648
Gloyne, H. F., 426
Glueck, H. I., 137
Gohar, M. A., 651
Goldman, J., *749
Goldsmith, G. A., 501
Gooding, C. G., 894
Goodwin, M. S., *10
Goodyear, W. E., *1208
Gordon, H. H., 888
Gordon, I., *588
Goss, A. S., 778
Gossels, C. L., 497
Goswell, G., 1246
de Graciansky, P., 503
Graham, E. A., *87
Graham F., J. C., 730
Graham, R. R., 647
Graham, R. H., 623
Granet, E., 127
Grant, W. T., 889
Grasset, L., 1316
Gray, I. R., 651
Green, D. H., 627
Green, H. H., 353
Green, W. L., 723
Greenberg, M., 720, *901
Greenblatt, R. B., 723
Greene, J. A., *1053
Greenfield, R. E., *616
Greengard, H., 1307
Greenspan, E., 424
Greenwald, I., 891
Griffin, W. D., *907
Griffith, G. C., *974
Griffiths, D. L., 806
Grille Cendan, V., 69
Grimson, K. S., 1307
Gros, C. M., 651
Gross, E. R., 1305
Gross, L., 800
Grossman, M. I., 1307
Grove, J. S., 647
Grubin, A. F., *752
Grynbaum, B., 351
Guerriero, W. F., *882
Guillot, M., 353
Guiteras, A. F., 803
Gunning, N. S., 429
Gunson, E. B., 727
Guri, J. P., 650
Guttmann, L., 1242
Guzman, F., 804

H

Haag, H. B., 850
Habel, K., 427
Haber, L., 725
Haberman, S., 201
Hadorn, W., 967
Hagerman, G., 1246
Hahn, R. D., 425
Hair, H. C., 727
Hairston, N. G., 132
Halbrecht, L., 69
Haldi, J., 202
Hall, S., 141
Halvorson, L. C., 781
Hamberger, C. A., 138
Hamburger, M., Jr., 137
Hamilton, T. R., 572
Hampton, O. P., Jr., 349
Hanley, F. W., 344
Hansen, A. E., *10, 1240
Hanson, M. C., *299
Harbitz, H. F., 142
Hardt, H. G., Jr., *907
Hargrove, S. W. G., 140
Harkins, H. N., 134
Harkness, A. H., 574
Harper, F. G., 1245
Harrington, D. O., *669, 719
Harrison, J. B., 725
Harrison, R. J., 574
Harrison, T., 1242
Hart, J. F., 891
Hartman, D. L., *392
Hartman, T. L., 723
Harvie, F. H., 647
Harving, F., 806
Harwood, H. B., 1172
Haskell, C. C., 645
Hassin, G. B., 1309
Hathaway, M. L., 202
Hatoff, A., 570
Havens, W. P., Jr., 501
Hayman, J. M., 570
Headings, D. M., 129
Heck, F. J., *147
Helmann, H., 1244
Helnle, R. W., 724, *739
Helander, S., 1246
Hellems, H. K., *522
Helsby, F. K., *407
Helweg-Larsen, H. F., 354, 895
Helwig, E. B., 1313
Hendrick, J. W., *1258
Henle, G., 648
Henle, W., 648
Herbert, F. K., 69
Heringman, E. C., *663
Hermans, E. H., 504
Hermon, R., 428
Hernandez Morales, F., 204
Hertz, S., 726
Hertzberg, G., 1247
Herz, E., *476
Hess, A. D., 201
Hess, V. F., 1305
Hess, W., 141
Heterick, R. H., 725
Heuer, G. J., 725
Heurtematte, A., 353
Hewlett, J. S., 1171
Heyman, A., *16
Heyns, O. S., 1037
Higgins, G., 197
High, R. H., 804, 1245
Higley, C. S., 61
Hill, A. J., Jr., *10, 886
Hill, J. M., 201
Hill, K. R., 69
Hill, M. R., *456
Hill, T. S., *445
Hill, W. R., 1036, 1244
Hines, M. O., 351
Hinman, F., Jr., 132
Hinshaw, H. C., 269
Hinton, J. W., 500
Hirsch, E., *1263
Hirsh, H. L., 270, *657, 1171, 1309
Hoagland, C. L., 499, *1181
Hochberg, L. A., 804
Hodes, R., 719
Hodges, F. J., 272
Hoff, H., 1306
Hoffman, R. S., 720
Hoffmann, W., 652
Holbrook, C. S., 65
Hollander, F., 1307
Holley, H. L., 1305
Holley, S. W., 573
Holman, C. W., 863
Holman, H. D., 136
Holmes, H. N., 649
Holzer, C. E., 1036
Hooper, J. M., *815
Hopkins, J. G., 886
Hopkins, L. A., 268
Hopp, E. S., 133, 645
Hornick, E. J., 135
Horrax, G., 273
Houghton, L. E., 805
Houston, C. S., 650
Howard, G. T., Jr., 427
Howard, M. A., 204
Howell, K. M., 1242
Hoyne, A. L., *661, 721
Huang, C. H., 571
Huebner, R. J., 272, *901
Hughes, R. R., 352
Hultquist, G. T., 730, 1318
Humble, J. G., 729
Humphrey, F. A., 778
Hunnicutt, L. G., *84
Hunnilen, A. V., 1242
Hunter, C. A., 271
Hunwicke, R. F., 727
Hussey, H. H., 1171
Hustin, A., 1038
Hutter, S., 1247
Hyman, M. E., 1310

I

Ignacio, P., 351
Ingersoll, F. M., 1035
Ingraham, H. S., 207
Ingraham, N. R., *10, 886
Ipsen, J., 1243
Irons, J. V., *813, *815, *819, *820
Irwin, C. E., *231
Isaacson, N. H., 1171
Ittner, E. J., *78
Ivy, A. C., *373, 1307

J

Jacobson, S. D., 127
Jahr, H. M., 197
Jakobowicz, R., 805
Jankelson, I. R., 1240
Jansen, C. A. L., 1317
Jeans, P. C., *245
Jennett, R., *832
Jennings, R., 1303
Jervell, O., 504
Jørgensen, J., 1316
Johannsmann, R. J., 886
Johnson, B., *675
Johnson, L. V., 647
Johnson, R. W., Jr., 723
Johnson, W. M., 1238
Johnstone, W. M., 647
Jones, C. M., *741
Jones, C. W., 139
Jones, J. P., 864
Jones, R. N., 503
Jones, T. D., 203
Josselyn, D. W., 124
Jost, H., *445
Jouve, A., 353
Juillard, J., 729

K

Kabat, H., 139
Kaiser, A. D., 130
Kaleita, E., 202
Kaminski, S. D., 431
Kane, C. A., 570
Kane, L. W., 501
Kantor, J. L., 1238
Kaplan, H. S., 135
Kaplan, I. I., 1245
Karellitz, S., 1310
Karotkin, L., 139
Keisselbach, M., 425
Keitel H. G., 345, 716
Kendall, F. E., 133
Kendrick, P., 268
Kennedy, J. D., 134
Kennedy, R. L. J., 648
Kent, J. F., *1001
Kepler, E. J., 136
Kerr, J. G., *1003
Kerr, M., 140
Kersley, G. D., 67
Kesson, C. M., 574
Kettel, K., 63
Kiefer, E. D., *1055
Kimbell, I., Jr., 649
King, A. G., 129
King, E. J., 208
Kinney, T. D., 1035
Kintner, A. R., *1207
Kirby, W. M. M., 571
Kirk, G. R., 428
Kisman, M., 1172
Kittle, C. F., *1202
Kjaergaard, H., 504
Klatskin, G., 500
Kleckner, M. S., *998
Klein, I. F., *901
Klein, J., 129
Klemme, R. M., 1241
Klinefelter, H. F., Jr., 722
Klotz, S. D., 891
Klyueva, N. G., 1038
Knoll, E. W., 1242
Knott, E. M., 1240
Knutson, J. W., 573
Kollbrunner, F., 967
Kooperstein, S. I., 499
Kooy, A. N. F., 968
Koteen, H., 425, 1241
Kouwer, C. H., 715
Kovnat, M., *963
Kreutzfeldt, H., 431
Krisnapoller, N. H., 430
Kullman, J., 70
Kulsegg-Hanssen, K., 574
Kunkel, H. G., 499, *1181
Kunstadter, R. H., 800
Kupperman, H. S., 723
Kurland, G. S., 271
Kurtz, L. D., 570
Kushlan, S. D., 716
Kutler, W., *29

L

Labby, D. H., 499, *1181
Lachnit, V., 967
Laipply, T. C., 273
Lamb, M., *299
Lancaster, J. E., *1211
Lancaster, W. B., *1211
Langer, L., 895
Langmuir, A. D., *588
Lapenta, R. G., 207
Largent, E. J., 1309
Larrabee, M. G., 719
Larsen, K., 274
Larson, C. B., 1308
Latour, J. P. A., 1035
Laufer, M. W., 724
Lavery, F. S., 67
Lavietes, P. H., 570
Law, W. A., 1308
Lawrence, H., 886
LeCompte, C. B., 139
LeCompte, P. M., 351
Leifer, W., *1
Leitner, S. J., 730
Lemierre, 651
Lemish, S., 349
Lemon, H. M., 137
L'Engle, C. S., Jr., 203
Lennox, B., 1246
Lennox, W. G., 130
Lequime, J., 729
Leriche, R., 429
Leslie, A., *994
Letton, A. H., 1245
Leutscher, J. A., Jr., 136
Levatin, P., 1306
Levens, J. H., 350
Levin, M., 130
Levin, O. S., 63
Levy, M. S., 136
Lewis, C. F., 501
Lewis, D. B., 1243
Lewis, E. L., 965
Lewis, I., 207
Lewis, L., 1171
Lhermitte, J., 806
Lichtman, A. L., 206
Limarzi, L. R., 201
Linas, S., *105
Lindberg, R. B., 725
Lindgren, I., 1318
Lindskog, G. E., 132
Linn, H. W., 728
Linton, R. R., *1268
Lipkina, A. Y., 652
Lipman, B. L., 427
Lipsitch, L. S., 571
List, C. F., 272
Liu, P. Y., 131
Livingood, C. S., 892
Livingston, S., *1060
Lobo-Parga, G., 1247
Lockie, L. M., *754
Loeb, W. M., Jr., *445
Loewe, L., 61, 62, *1263
Lommen, A., 354
London, I. M., 570
Longcope, W. T., 136
Lorimer, W. S., Jr., *21
Low-Beer, B. V. A., 65
Lozner, E. L., 349
Lucke, B., 572
Ludvigsen, K., 354, 895
Lumb, G., 805
Lund, H. Z., 129
Lundy, J. S., 890
Lutembacher, R., 1172
Lyford, J., III, 723
Lyle, D. S., *517
Lynch, E. M., 803
Lynch, F. W., *306
Lyon, G. M., 725
Lyon, R. A., 886
Lyons, C., *215
Lyons, R. H., 66
Lyons, W. R., 1308

M

Macaulay, W. L., 139
McCain, I., 1312
McCain, P. P., 1312
McCormick, C. O., 801
McCoy, W. C., 65
McCrea, J. F., 67
McCrea, L. E., 965
McCutcheon, A., 574
McDermott, W., 1241
McDonald, J. R., 138, 206
McEachern, D., 1306
Macfarlane, R. G., 805
McGavack, T. H., 891
McGee, C. J., 427
McGregor, T., 1305
Machi, D. J., 205
McKay, F. S., 499
McKell, D. M., Jr., *1055
Mackenzie, I. A. R., 1316
McKenzie, K. G., 134
McKittrick, L. S., 271
McLaughlin, R. S., 719
McNaught, R. B., 571
MacNeill, A. E., 1237
McNiff, W. T., 1305
Macomber, D. W., 649
MacPhail, A., 894
Macpherson, A., 69
MacVine, J. S., 727
Madigan, D. G., 1246
Madonick, M. J., 133
Magnuson, H. J., 136
Magnusson, J. H., 968
MaGovern, J. J., 127
Maler, J., 132
Malmon, S. N., 205, 206
Mallory, G. K., 1035
Manheims, P. J., 206
Mann, F. C., 206
Mann, I., 1315
Mann, K. J., 502
Manshardt, D. O., 1313
Manson-Bahr, P., 894
Mantooth, W. B., *832
Marble, A., 271
Marcuse, P., 139
Maris, E. P., 501
Marques, V., 208
Marshak, A., 1245
Marshall, F. A., *1007
Martin, L., 1037
Martin, N. H., 1315
Martland, H. S., 1242
Marvin, J. F., 887
Mason, P., 345
Mason, P. K., 888
Massell, B. F., 203
Masten, A. R., 63
Mateer, J. G., *909
Matheson, A., 727
Mathews, K. P., 128
Mawson, R., 352
May, H., 206
Mayer-Gross, W., 573
Mayers, A. N., 725
Mayers, E. B., 725
Mayfield, F. H., 650
Maynard, L. A., 202
Meadors, M. L., 552
Meads, M., 426
Mech, K. F., 349
Meigs, J. V., *75, 1035
Melchior, E., 503
Meleney, F. L., 426, *675
Mellanby, E., 805, 1316
Mendez, A., 70
Menefee, E. E., 204
Meredith, H. V., 719
Merei, J., 1318
Merrill, A. J., 424
Mertz, E., 782
Merz, E. H., 62
Meyer, K. F., *822
Meyer, L. M., 1306
Michel, M. L., Jr., *395
Michelsen, J. J., 721
Miletti, M., 430
Miller, A. L., 555
Miller, E. M., *461

Miller, H. C., 271
Miller, L., 127
Milligan, W. L., 68
Mlln, D. C., 208
Milstone, J. H., 350, 725
Minnhaar, T. C., 1248
Mirizzi, P. L., 730
Moffat, D. A., *1060
Mollneux, W. L., 348
Moloney, W. C., 726
Moloshok, R. E., 1310
Monnet, R., 729
Montero, E., 1247
Moon, H. D., 134
Moore, B. E., 649
Moore, F. D., 426, *741
Moore, R. A., 724
Morales, P., 804
Moran, W. G., 351
Morgan, A. D., 805
Morgan, D., 206
Morgan, E. A., 1242
Morin, L. J., *963
Moritz, A. R., 721
Morris, S. I., 62
Morrison, J. L., 424
Mortensen, V., 504
Morton, G., 1306
Moses, W. R., 205
Moss, M. J., 135
Most, H., 570
Mouzon, M., 503
Mudd, S., 892
Muir, E., 967
Muir, J. B. G., 894
Mulholland, H. B., 861
Munck, W., 968
Munkelt, F. H., 344
Murphy, J. N., Jr., *819
Murray, G. E., 1311
Murray, M. M., 728
Musella, M., 198
Mushett, C. W., 1242
Musselman, M. M., 501
Myers, W. K., *1205

N

Naclerio, E., 895
Naffziger, H. C., 1168
Nagler, S. H., *755
Nath, H. P., 68
Navarre, R. J., 351
Neefe, J. R., 890
Nesbit, R. M., *296, 1311
Neumann, H. H., 1037
Newhouser, L. R., 349
Newman, A. A., 424
Newman, F. W., 350
Newman, H. W., 270
Newton, F. C., 1168
Nickeson, R. W., 200
Niehaus, R. F., 1304
Nixon, N., 1243
Nørgaard, O., 1248
Norcross, B. M., *754
Nordenson, N. G., 504
Norman, J. S., *771
Noro, L., 652
Norris, E. H., 63
Norris, J. L., 803
Norwood, W. D., 1307
Nourse, M. Y., *366
Novy, F. G., Jr., 889
Nutini, L. G., 803

O

Ober, R. E., 965
O'Brien, D. E., *691
O'Brien, J. R. P., 197
Ochsner, A., 351
Odell, L. D., *735
Öhnell, H., 430
Øming, K., 208
Ogura, J. H., 137
O'Leary, J. L., 721
Olin, H. A., 1245
Oliver, D. S., 649
O'Neil, B., 270
Osgood, C. W., *104
Ostro, M., 205
Ostroff, R. A., 197
Ou, Y., 131
Oyster, J. M., 424

P

Pace, N., 1304
Paddock, F. K., 888
Padgett, E. C., 268
Page, S. G., Jr., 427
Pagel, W., 141
Palmer, R. E., 129
Palmer, W. L., 205, 206
Parker, C. S., 274
Parmley, R. T., 129
Parran, T., *1047
Pasquier, C., 353
Patek, A. J., 427, 715
Paul, J. R., 1303
Paul, J. T., 201
Payne, E. H., 893, 893
Peacock, W. C., 426
Pearlman, R. C., 206
Pearson, E. F., 501
Pelczar, M. J., 726
Pellittori, O., *901
Pelz, M. D., 800
Pendergrass, E. P., 130
Pendl, O., 967
Penfold, J. B., 503
Perera, G. A., 499
Perkins, J. E., 1304
Perkins, R. F., 724
Perkins, W., 349
Perlman, R., *771
Pernworth, P., 1308
Perrault, M., 353
Perry, D. J., 891, 892
Perryman, C. R., 130
Peterkin, G. A. G., 727
Peterson, J. C., 202, *1277
Peterson, L. J., *339
Pettersson, A., 968
Pfandler, U., 1247
Pfuetze, K. H., 269, 648
Phelps, P. S., *359
Phillips, E., *161
Phillips, F. R., 649
Philpott, N. W., 1035
Platt, A. D., 65
Pierce, G. S., 348
Pillsbury, D. M., *1255
Pitts, G. C., 1304
Pitts, W. R., 1240
Platou, R. V., *10, 886
Platzer, R. F., 206
Plumb, R. T., *296, *579, 1311
Poate, H. R. G., 1172
Poindexter, A., 128
Poindexter, C. A., 885
Polatin, P., 726
Polishuk, Z., 890
Pollard, M., 131
Pollock, L. A., 502
Pompen, A. W. M., 1317
Poncher, H. G., 198, 201
Pool, T. L., *584
Poole, F. E., *91
Poppe, K., 204
Potter, R., 425
Power, M. H., 136
Pratt, J. J., Jr., 725
Pratt-Thomas, H. R., *600
Priest, W. S., 427
Proctor, L. D., 134
Pulaski, E. J., 571, 1036
Purdie, I. A., 429
Putnam, T. J., 1306
Pyke, M., 727

Q

Quinby, W. C., 203
Quintos, F. N., 1306

R

Rae, V. M., 208
Ragan, C., 499, *752
Rammelkamp, C. H., *588
Ramsey, H., 350
Randall, J. H., *735
Randolph, N. M., 1305
Rangell, L., *755
Rantz, L. A., 132
Rapoport, P., 1171
Rapoport, S., 893
Ratcliffe, H. L., 888
Rath, M. M., 127
Ratliff, R. K., *296
Ratner, B., 497
Ravenel, S. F., *989
Reben, H., 1317
Rechenberg, H. K., 141
Redlich, F. C., 649
Reed, H., 68
Rees, H. M., *613
Reese, H. H., 201
Reeves, G. S., 571
Reid, D. E., 425
Reid, H., 651
Reid, R., 503
Reimann, H. A., 131
Rein, C. R., *1001
Reinhold, J. G., 890
Remington, J. H., 890
Rémy, R., 1038
Reveno, W. S., *1190
Reyersbach, G. C., 1310
Reyes, E., 269
Rhoads, E. E., 135
Rhoads, J. E., 1168
Rhoden, A. E., 723
Rhoden, P., 728
Rhodes, A. J., 140
Rieben, W. K., 69
Ring, G. C., 1304
Riseman, J. E. F., 271
Ritter, F. A., 1237
Rives, J. D., *663
Robbins, S. L., 1035
Roberts, A., 726
Robertson, K., 502
Robin, J. P., 429
Röder, F., 1237
Roen, P. R., 570
Rogen, A. S., 1315
Rohmer, J. A., 729
Rohmer, P., 729
Roman Crespo, J., 1247
Rosberg, M., 1248
Rose, A. S., *5
Rose, H. M., 269
Rosellini, L. J., 204
Rosenbaum, H. D., 571
Rosenberg, A., 888
Rosenberger, H. G., 720
Rosenblatt, P., 61
Rosenfeld, R. T., 349
Rosenfeld, S. Z., *392
Rosh, R., 1245
Roskin, G., 1038, 1038
Ross, S., 892
Rosser, C., 893, *1003
Roth, D. B., 427
Roth, H., 968
Rothschild, K., 124
Rotman-Kavka, G., *657, 1309
Rowe, A. H., 720
Rubenstein, A. D., 1311
Rubin, I. C., 726
Ruckert, C. W., 887
Ruddock, J. C., 572
Ruffin, J. M., 1307, 1313
Ruggiero, W. F., 272
Ruhstaller, F. D., 1310
Rupp, C., Jr., *509
Rusinov, V. S., 431
Russek, H. I., 127
Rustigian, R., *224
Ryan, J. J., 721
Rytand, D. A., 571

S

Sabin, A. B., *281
Sabon, F., 729
Saccomanno, G., 1241
Sachs, R. R., 1307
Sacrez, R., 729
Sadovsky, A., 890
Sadusk, J. F., Jr., *1192
Sagall, E. L., 271
Sagher, F., 269
Salley, S. M., 722
Saltzman, A., 424
Sampson, J. J., 129
Sanderson, A. G., 138
Sanford, H. N., *691
Sapelka, N., 894
Sapero, J. J., 966
Sargent, J. C., 550
Savilahti, M., 274
Sawyer, C. G., 61
Saxholm, R., 1318
Schafer, P. W., *1202
Schaubel, H. J., 269, 648
Schepers, G. W. H., 127
Schilling, J. A., 273
Schlesinger, E. B., 499
Schneck, J. M., 202
Schneider, M., 650
Schneider, P., 131
Schneiderbaur, A., 1172
Schnurman, A. G., 1036
Scholtz, W. deV., 503
Schools, P. E., *359
Schornagel, H. E., 1172
Schroeder, E. C., 570
Schroff, J., 345
Schulz, M. D., *741
Schumacher, H. C., 649
Schur, M., 888
Schwartz, B. S., 350
Schwartzberg, S., *393
Scobey, R. R., 721
Scott, J. W., *735
Scott, R. B., 574, 723
Scott, R. W., 129
Scribner, W. E., 205
Secretan, J. P., 430
Seed, L., *907
Segers, M., 729
Seidmann, M., 1248
Seitz, C. P., 1308
Seldon, T. B., 885
Seligman, A. M., 426
Sellgman, E., *87
Sellkoff, I. J., 804
Selverstone, B., 205
Selye, H., 64
Senez, J., 353
Senger, F. L., 1311
Sensenbach, W., 348
Sensenich, R. L., 548
Sepulveda de Horquez, H., 1247
Sewell, C. W., 863
Shallow, T. A., 966, 1241
Shanahan, W. M., 135
Shank, R. E., 499, *1181
Shapiro, R. L., 803
Sharpey-Schafer, E. P., 805
Shepard, C. C., *813
Shippel, S., 1037
Shookhoff, H. B., 720
Shoulders, H. H., 866
Shumacker, H. B., Jr., 1313
Silva, J. A., 351
Silverglade, A., 424
Silverman, D. N., *994
Silverstein, J., *907
Simon, B., 721
Simon, J. L., 724
Simpson, D. G., 1037
Sjögren, B., 1246
Skogland, J. E., 201
Slater, B. J., 803
Sloan, H. P., 891
Slobe, F. W., 803
Small, J. T., *459
Smith, B. H., 68
Smith, C. E., 720
Smith, D. T., 205
Smith, F. G., 732
Smith, G. M., 1308
Smith, H. L., 200
Smith, J. M., 427
Smith, R. C., 1307, 1313
Smith, W. J. J., *27
Smith, W. W., 1309
Smith-Petersen, M. N., 1308
Smolens, J., 892
Snapper, I., 64, *157, 424
Snell, A. M., *981, *1175
Snyder, H. E., *219
Sokolow, M., *981
Solomon, H. C., *5
Solomon, M. L., *105
Sommerfelt, C., 208
Sorsby, A., 428
Spain, A. W., 727, 727
Spatt, S. D., 129
Spence, H. M., 1311
Speranski, A. D., 431
Spies, T. D., 206, 425
Spink, W. W., 132
Spitz, S., 573
Spotnitz, H., 726
Stamps, P., 272
Stangl, A., 431
Stare, F. J., *169
Starr, C. G., 779
Staub, H., 353
Steele, H. H., *909
Stefanini, C., 429
Steiger, H. P., *1255
Steiner, A., 133
Steiner, P. E., 133
Stenstrom, K. W., 887
Stept, R. B., 570
Sternberg, T. H., *1
Stevens, G. A., 722, 891
Steves, R. J., *306
Stevick, C. P., 204
Stewart, A. T., 860
Stewart, H. J., 424
Stewart, J. D., *216
Stewart, J. Y., 63
Stokes, E. H., 429
Stokes, J., Jr., 350, 501
Stone, H., 64
Stone, J. D., 67, 140
Stout, A. P., 722
Stransky, E., 1306
Strauss, E., *588
Strauss, E. B., 894
Strom, J. E., 202
Stuart, H. C., 719
Stuart, R. D., 140
Stuart-Harris, C. H., 274
Sturgis, C. C., 570
Suarez, R. M., 724
Suess, J. F., 1306
Sullivan, C. J., *178
Sulzberger, M. B., *293
Susselman, S., 500
Sutherland, C., 728
Swan, C., 1316
Swart, C. M., 554
Sweet, L. K., *657
Sweet, R. H., 205, 1310, 1310
Sweetapple, H. A., 429
Sweigert, C. F., 886
Swenson, R. E., 424
Swift, P. N., 1246

T

Tandowsky, R. M., 424
Tanna, J. F., 1241
Taquini, A. C., 61
Tarlov, I. M., *476
Tartakoff, S., 351
Tassman, I. S., 1306
Taube, H., 724
Taussig, H. B., 1303
Taylor, C. A., 345
Taylor, C. F., 63
Taylor, H. C., Jr., 131, 1313
Taylor, M. D., 428
Taylor, W. W., 62
Tepper, W. R., 892
Tesar, W. C., *820
Thetford, N. D., 268
Thiebaut, F., 430
Thomas, E. W., 888
Thomas, E. W. P., 1246
Thomas, M. P., 572
Thometz, A. F., *373
Thompson, B. C., 887
Thompson, F. G., Jr., 1311
Thompson, G. J., *366
Thompson, M., 268
Thomson, J. E. M., 66
Thorek, P., *21
Thygeson, P., *437
Tidy, H., 728
Tisdall, F. F., 647
Todd, J., 886
Törnell, E., 504
Topping, N. H., *813
Tostevin, A. L., 1316
Trager, W., 132
Treloar, A. E., 1036
Tricerri, F. E. P., 895
Trinção, C., 142
Tucker, J. L., 892
Turner, C. E., 1304
Turner, J. W., 886
Turner, L., 137
Tuttle, A. D., 1308
Twombly, G. H., 131
Tyson, W. G., 137

U

Udaondo, C. B., 806
Uhde, G. I., 889
Ulmer, J. L., 650
Ungar, J., 428
Urioste, R., 503
Ustvedt, H. J., 67, 1318
Utterback, R. A., 1241

V

Vallee, B., 137
VanderLaan, W. P., 500
van Dorssen, G. J. E., 1035
van Herick, W., 1303
van Heuven, J. A., 70
van Ouwerkerk, L. W., 652
Van Rooy, C. W., 204
Van Rooyen, C. E., 428
Van Wagenen, W. P., 273
Varco, R. L., 1314
Vaughan, V. C., 203
de Vernejoul, R., 729
Vilter, C. F., 206
Vivino, J. J., 1309
Vogel, M., 891
Voress, Heide, E. C., 127
Von Hagen, K. O., 889, 889
von Oettingen, W. F., 1309
Vujic, V., 895

W

Waddell, W. W., Jr., 203
Wade, L. J., 64
Wagener, H. P., 200
Wagner, F. B., Jr., 965, 966, 1241
Walker, J. E., 890
Walker, J. W., 573
Walker, N. F., 1032
Wallace, W. M., *1280
Wallerstein, R., 137
Walters, W., *459
Wangensteen, O. H., 1036
Ward, A. T., Jr., *1060
Warin, R. P., 574
Warren, H. A., 61
Warren, L. O., Jr., 1311
Warren, S., *462
Washington, E. L., 724
Wasserman, L. R., 1310
Watkins, A. L., 721
Watrous, R. M., 269
Watts, J. W., 891
Way, S., 428
Weagley, R. C., 781
Webster, B., 1241
Weijtlandt, J. A., 503

133
947

Weil, H. R., *393
Weil, P. E., 1172
Weinstein, L., *963
Weinstein, L., 887
Weinstein, L. J., 719
Weiskotten, H. G., *1045
Weisman, A. I., 198
Weiss, J. A., 206
Weitzen, H. G., 1306
Welch, A. D., 724, *739
Welch, C. E., 132
Weld, S. B., 553
Wellin, S., 138
Wenner, H. A., 1303, 1314
Wertham, F., 645
Wetzel, E., 652
Weymuller, C. A., *78
Wharton, L. H., 967
Wheeler, E. O., *16
Whishaw, R., 352
Whitacre, F. E., *445
White, E. F., Jr., 648
White, J. C., 574
White, P. D., *16
Whiting, E. G., 720
Wichtl, O., 354
Wickham, W. A., 891
Widmann, R., *604
Wieberdink, J., 208
Wiederhold, A., 70
Wiener, A. S., 885
Wiese, H. F., 1240
Wiesner, B. P., 140
Wilbur, D. L., 1171
Wilder, R. M., Jr., *522
Wilhelm, F., 1171
Wilkinson, E. E., *10
Willcox, R. R., 428
Willerson, D., *393
Williams, D. L., 966
Williams, H. A., 273
Williams, J. L. D., 428
Williams, O. L., 1308
Wilson, D. C., 728
Wilson, D. J., 200
Wilson, G., *509
Wilson, J. W., *459
Wilson, R. A., 1243
Winckel, C. W. F., 431
Windle, W. F., 125
Winkenwerder, W. L., 1242
Winkler, A. W., 135
Wiprud, T., 624
Wird, K., 968
Wirth, W. R., *395
Wirtschafter, Z. T., *604
Wishart, D. E. S., 1242
Wishart, J. H., *539
With, T. K., 1316
Witts, L. J., 1315
Wolf, W., 344
Wolfe, D. M., *819
Wolfer, J. A., 1313
Wolman, I. J., 128
Wood, G., 64
Wood, M. N., 1240
Wramner, Z., 1248
Wright, C. S., 1305
Wright, G. P., 573
Wright, H. S., Jr., 722
Wuerthele, V., 1312
Wynn, W., 202

Y

Yeomans, F. C., 272
Yerushalmy, J., *359
Young, B. R., 500
Young, M. D., 201

Z

Zabludovich, S., 430
Zacks, D., *359
Zamcheck, N., 721
Zimmerman, H. M., 268
Zinnemann, K., 894
Zohman, B. L., 127
Zollinger, R., 1038
Zuidema, P., 430
Zwerling, H. B., 1245

INDEX TO PAGES

OF THE JOURNAL, ACCORDING TO WEEKLY ISSUES—VOLUME 133, JANUARY—APRIL, 1947

Pages	No.	Date
1— 74	1	Jan. 4
75— 146	2	Jan. 11
147— 214	3	Jan. 18
215— 280	4	Jan. 25
281— 358	5	Feb. 1
359— 436	6	Feb. 8
437— 508	7	Feb. 15
509— 578	8	Feb. 22
579— 656	9	March 1
657— 734	10	March 8
735— 812	11	March 15
813— 900	12	March 22
901— 970	13	March 29
971—1044	14	April 5
1045—1174	15	April 12
1175—1254	16	April 19
1255—1372	17	April 26

V 1
194

3796